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The 1929 Local Government Act : the formulation and implementation of the poor law (health care) and exchequer grant reforms for England and Wales (outside London).

THE 1929 LOCAL GOVERNMENT ACT: THE FORMULATION AND IMPLEMENTATION OF THE POOR LAW (HEALTH CARE) AND EXCHEQUER GRANT REFORMS FOR ENGLAND AND WALES (OUTSIDE LONDON)

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by

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ABSTRACT

This thesis reports the findings of new inquiry in to the formulation and implementation of the 1929 Local Government Act. It focuses on two reforms contained within the Act: first, the reform of local health care and local government structure that was contained within the reform of the poor law; and secondly, the reform of exchequer grants through the introduction of a block grant.

Chapter one provides an explanatory introduction to the reforms, and a synthesis of existing literature broadly favourable to them, which is concerned to define common themes of interpretation of their formulation and implementation. Chapter two questions the intellectual basis of such literature, discusses the critical orthodoxy on the reforms, and proposes an alternative theoretical perspective which may be used as a basis for their reconsideration. The chapter ends by offering new perspectives on the origins of reform proposals immediately after the First World War.

Chapter three then analyses the development of the reforms in the Ministry of Health between 1921 and 1924, and reveals the controversy that debate aroused. Chapter four completes the analysis of formulation by analysing the political motives for reform of Neville Chamberlain, and the political partiality of the Ministry of Health. It also analyses the extent to which interests outside government were involved in the creation and revision of reform and the implications for the reforms aims of the access given to the local authority associations.

Chapters five and six are concerned with the implementation of the reforms. Chapter five assesses the record of the block grant as a grant-aid control, and as a means of redistributing grant aid in relation to need during the 1930s. Chapter six assesses the nature of local authority health care in the 1930s after reform, and the impact theron of the block grant and the system of central control associated with the block grant. Both chapters assess the implications of the experience of implementation for later reform.

The conclusion is concerned to draw together the new perspectives offered by these chapters, and with an attempt to locate the significance of the 1929 Local Government Act as a whole in the long-term development of local government, central-local relations and social policy reform.

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AUTHOR'S DECLARATION

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Jonathan Bradbury

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CHAPTER ONE

INTRODUCTION

The 1929 Local Government Act was introduced to Parliament by the then Minister of Health, Neville Chamberlain, and came in to force on the appointed day of April 1st 1930. The Act comprised a number of reforms separately developed. Inter alia it is notable for setting in progress the regrouping of district councils through a review procedure to be carried out by county councils. It also extended the powers of county councils over road administration, gave additional planning powers to county councils and county boroughs, and empowered borough councils to initiate town plans. The administration of births, deaths and marriage registration, for long a function of the poor law authorities, was passed to the county and county borough councils. With regard to local sources of finance, agricultural land and farm buildings were made totally exempt from paying the rates, having previously been 3/4 exempt, and industrial property and the railways, originally fully liable for local rates, were made liable only for 1/4 of their rates bill.[1]

These were important changes, but the two reforms which earned most attention from contemporaries, and have continued to engage the most attention from historians, were those contained in Parts I and VI of the Act. Part

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1 For a brief introduction to the contents of the 1929 Local Government Act, see C.L.Mowat, Britain Between the Wars, 1918- 1940 (1955), pp.340-342.

I reformed the poor law and Part VI reformed the system of central finance to local authorities through exchequer grants. It is these reforms with which this thesis is directly concerned, although it should be stressed that the thesis is primarily concerned to analyse the reform of the poor law as a reform of local government and as a reform of the organisation of local health care. In addition, it must be noted that the 1929 Act contained separate provisions for reform in relation to London. These lie outside the consideration of this thesis. Finally, it should be noted that the analysis in the thesis is primarily based on qualitative, rather than quantitative, evidence.

Even though the scope of the thesis is limited in this way it is hoped that analysis of significant parts of the 1929 Local Government Act may be made, and through this a contribution to an understanding of the whole Act. Through such a study it is further hoped that some response may be given to those historians who draw attention to the fact that local government, central-local relations and their roles in public policy-making still remain amongst the greatest imponderables in our understanding of inter-war domestic history.[2]

This chapter will first, seek to explain the context of the poor law (health care) and exchequer grant reforms, in particular discussing the nature of local government, local health provision and central-local

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2 See, for example, E.P.Hennock, 'Central/Local Government Relations in England: an outline, 1800-1950' in the Urban History Yearbook (1982), pp.38-50.

financial relations before 1929. It will then explain the content of the reforms. Finally, the chapter will bring together some of the main findings of empirically based research on the historical problems posed by the reforms as a received orthodoxy which then may be examined.

1. LOCAL GOVERNMENT AND CENTRAL-LOCAL RELATIONS BEFORE 1929

In 1929 there were two systems of elected local government in England and Wales: the local authorities, created by the local government acts of 1888, 1894 and 1899; and the poor law authorities, created by the Poor Law Amendment Act of 1834. Each had their own separate methods of operation, responsibilities and framework of relations with central government.

(i) LOCAL AUTHORITIES AND CENTRAL GOVERNMENT

Outside London local government areas took two forms: the county boroughs and the administrative counties.[3] The county boroughs were urban areas of over 50,000 population and their councils were all-purpose

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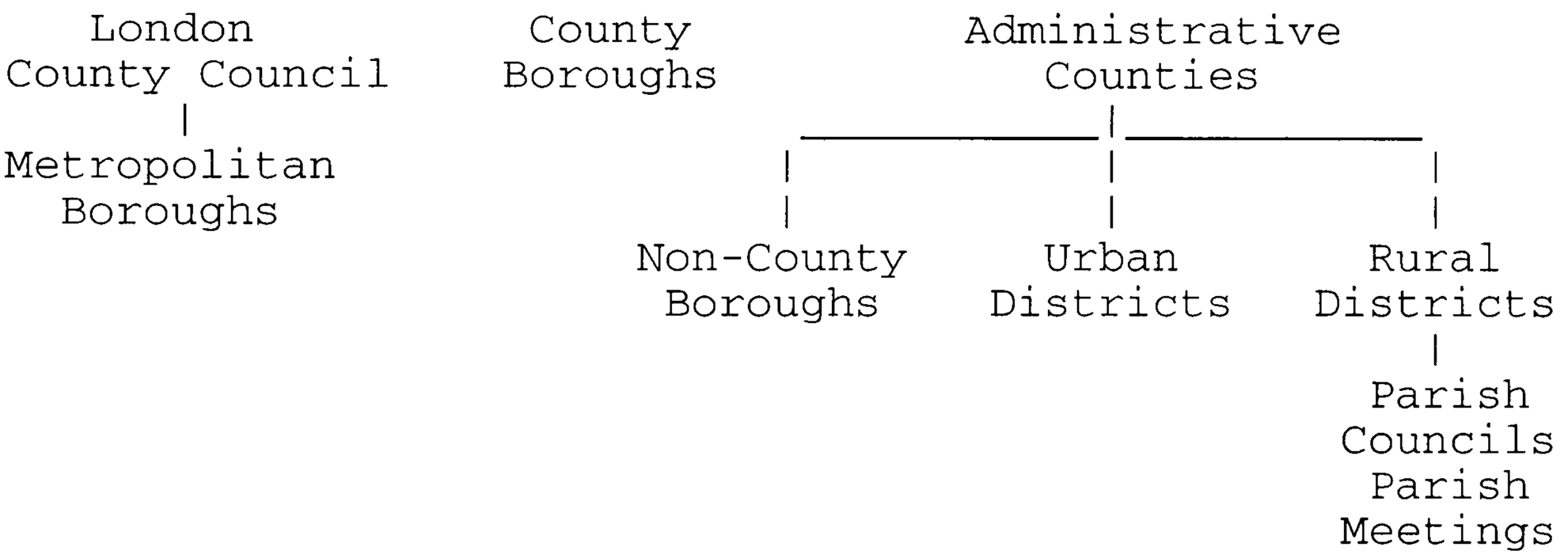
3 Much of the following discussion is based upon H.J.Laski, W.I.Jennings, W.A.Robson ed, A Century of Municipal Progress 1835-1935 (1935), K.B.Smellie, A History of Local Government (1946), J.H.Warren, Local Government (1950), J.Stanyer, Understanding Local Government (1976), B.Keith-Lucas and P.G.Richards, A History of Local Government in the Twentieth Century (1978) and M.Loughlin, M.D.Gelfand and K.Young, Half a Century of Municipal Decline (1985).

authorities. In 1919 there were eighty two of these with Doncaster being the single addition during the next twenty years. The sixty two administrative counties covered the rest of the country. In each administrative county there were three tiers of local government. The principal authority was the county council, which administered the majority of services over the whole county area. Beneath the county council were the non-county boroughs and urban and rural district councils, collectively known as the second tier authorities, which administered certain services within their own areas. The most local form of county government was conducted in a variety of forms at the parish level.

Figure 1 The Structure of local government



(Source: P.G.Richards, The Reformed Local Government System (1973), p.23)

Local authorities shared certain common political features. They were made up of councillors elected by a franchise wholly within the local authority area. Under the 1918 Representation of the People Act, amended by an Act of the same name in 1928, this franchise was

standardised.[4] There was also some indirect representation. On county borough and county councils a third of the council membership was made up of aldermen who were elected for longer periods by the councillors themselves. Generally, aldermen were elected from among the councillors in recognition of long service or particular abilities, but they could extraordinarily be elected from outside. In county and non-county boroughs council leadership was vested in a mayor elected by aldermen and councillors. In county and urban and rural district councils the same power was vested in a chairman. These arrangements ensured that local authorities were made up of members who were either directly or indirectly accountable to their local electorate, thus giving local authorities a democratic basis for autonomous policy making, although only in relation to matters designated by parliament.

The structure of the policy making process in local authorities also had common features. Committees of

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4 See B.Keith-Lucas, The English Local Government Franchise (1952), pp.226-236. The local franchise was held by any person of full age who had occupied land or premises in an area for six months, as well as their husband or wife who lived in the same premises. Such persons were also allowed to be elected, as well as landowners within the area who did not otherwise meet the electoral qualification. The 1918 Act also gave the vote in local elections to paupers, as long as they met the electoral qualifications. Although they remained banned from membership of boards of guardians the 1918 Act allowed paupers to stand for election to county and county borough councils. A provision in the 1929 Local Government Act eliminated this possibility, and the 1933 Local Government Act banned those in receipt of public assistance from representation on any local authority. See also J.P.D.Dunbabin, 'British Local Government Reforms: The Nineteenth Century and after', English Historical Review, vol 92, 1977, p.801.

members met to propose policies for individual services, which were then submitted to meetings of full council at monthly or quarterly intervals for discussion, amendment and resolution. The committees were then responsible for the execution of policy for individual services once it had been ratified by full council. In both the preparation and execution of policy committees could set up sub-committees and sometimes co-opt non-elected representatives for their specialist knowledge. Departments of local government officers assisted the members at all stages of their work but were essentially there to carry out the will of the elected members.[5]

In the period between 1889 and 1929 the statutory duties and powers of local authorities expanded variously to include work in relation to the provision of education, roads and planning, housing, and a range of public protection services such as fire cover and weights and measures inspection. The accretion of duties and powers in relation to health care played an integral part in this expansion.[6] From their inception county boroughs and second tier authorities were sanitary authorities, thus inheriting responsibility for the improvement on 19th century achievements in relation to water supply, drainage, sanitation and refuse disposal. Under the 1875 Public Health Act local authorities were given the power

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5 See H.J.Laski, 'The Committee System in Local Government' in Laski, Jennings and Robson ed, A Century of Municipal Progress, 1835-1935, pp.82-109; R.M.Jackson, The Machinery of Local Government (1958) pp.102-137.

6 See J.Parker, Local Health and Welfare Services (1965).

to set up general hospitals, and there followed the creation of further specific responsibilities.[7] County boroughs and county councils were given a statutory responsibility for providing institutional accommodation for those considered mentally ill under the 1890 Lunacy Act. In addition, county boroughs and second tier authorities provided hospitals for such infectious diseases as smallpox, and under the 1893 and 1901 Isolation Hospitals Acts county councils were empowered to set up hospital districts within county areas to enable joint action between county and second tier councils. By 1921 free local authority hospital bed provision had begun to rival that of the voluntary hospitals, although the former came primarily in the form of specialist provision.[8]

During the period of the First World War and after, however, local authorities acquired an even fuller range of health care responsibilities. Under the 1913 Mental Deficiency Act county boroughs and county councils were required to extend institutional accommodation to those considered mentally handicapped. In 1916 the public health (venereal diseases) regulations then pushed local authorities firmly into the field of out-patient care.

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7 Note that in the mid-19th century, hospital provision even for people, who whilst not being recipients of poor relief, could not afford to pay for treatment, was almost totally the preserve of the voluntary sector. The voluntary sector remained an important provider of hospitals into the twentieth century.

8 See R.Pinker, English Hospital Statistics,1861-1938 (1966), pp.72-79. During the 1920s local authority and voluntary providers were hotly to debate the issue of patient-charging to fund both existent and expanded provision.

County councils and county boroughs were required to provide centres for treatment and diagnosis, practitioners and drugs, and to examine any specimen provided by practitioners. The 1918 Maternity and Child Welfare Act extended the powers of county councils and county borough further by enabling them to provide a variety of maternity and child welfare services, including ante-natal and child welfare clinics, as well as subsidised milk and post-natal care.[9] The care of the young child complemented county and county borough responsibilities for the health of the child of school age, which had been acquired before the First World War and were extended in 1921. It should be noted, however, that some second tier local authorities became responsible for maternity and child welfare under the 1918 Act within their own areas. The 1920 Blind Persons Act then extended county and county borough council responsibilities for the handicapped. They were required to promote the welfare of the blind as well as providing them with technical education where appropriate. Finally, under the 1921 Public Health Act county and county borough councils were given the duty of providing out-patient dispensaries for the treatment of tuberculosis. They were also responsible for notification of the disease and keeping a register of sufferers, and at this

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9 J.Lewis, The Politics of Motherhood, Child and Maternal Welfare in England, 1900-1939 (1980), p.34.

time were encouraged to provide more sanitaria for the isolation of sufferers.[10]

In short, by 1929, as part of a considerable expansion of statutory duties and powers across a range of services the local authorities had become major local health care agencies. County borough councils were providers of sanitary, preventative, out-patient and some in-patient health care. In the counties the second tier authorities were still providers of sanitary services, some in-patient care, and in some cases maternity and child welfare services, but the county councils had risen to take responsibility for the remainder. In some county and county borough councils such was the burden of work that separate public health and maternity and child welfare committees were created.

In the execution of their health care responsibilities, as in all others, local authorities were dependent upon the revenue raised from the local rate.[11] This was based on the valuation of property, and the contribution of each ratepayer was based on the rate poundage set by a council at the beginning of a financial year to meet the costs of its budget. The existence of the rate was crucial for it allowed local authorities autonomy in making spending decisions. However, it also made them financially accountable to their electorates

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10 See N.Wilson, Municipal Health Services (1946), pp.1-122.

11 For further discussion of local authority finance in the inter-war period see A.H.Marshall, Financial Administration in Local Government (1960) and the articles by A.Collins on finance and local financial organisation in Municipal Review (1936).

and in the setting of each annual rate poundage local authorities had to bear in mind the level of rate which was desirable to their electorates. This placed a constraint on what aggregate level of rate-aided expenditure was possible. It then followed that all local authorities annually had to decide how that aggregate level of expenditure should be divided between different service responsibilities. Much of local authority politics was bound up in deciding aggregate levels of expenditure and then what slice of the cake each committee could win for its service responsibilities. Local authority spending on health services, as on all other services, was, therefore, habitually prey to the rate politics and service priorities of each and every local authority.[12]

The political and financial realities of local government drew it in to ever more complex sets of relationships with central government. This derived from the very fact that as state intervention had grown since the late 19th century Parliament had devolved direct responsibility for so many services to local government as the most appropriate institution of provision. Where such services were deemed to be of national importance central government was interested in the promotion of service development and the maintenance of standards consistent with central aims. It was considered essential that no service should suffer from the vagaries

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12 See, for example, J.P.Bradbury, Government and County, A History of Northamptonshire County Council, 1889-1989 (1989), p.46.

of individual council policies. Consequently, central government developed a system of relationships with local authorities which centred on the promotion of services at a local level and the control of the way in which those services were provided.[13]

At the heart of such a system was the provision of exchequer finance in aid of local services.[14] From 1888 central government had attempted to concentrate central finance through the granting to local government of the proceeds of a range of licences, duties and taxes, known collectively as the assigned revenues. It was hoped that such sources of finance would expand with the needs of local authorities. However, central departments concerned with the administration of individual services found that promotion and control of provision by local government was best facilitated by the alternative subvention of exchequer grants-in-aid of specific services, the most common form of which was the percentage grant.

The percentage grant promised that a considerable proportion of the cost of any local authority scheme would be met by the exchequer and was, therefore, a considerable inducement to local authorities to carry out their duties and powers enthusiastically and so achieve the kind of service development that central departments wanted. At the same time local authorities were required

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13 See Hennock, 'Central-Local relations in England:an outline, 1800-1950', Urban History Yearbook (1982), pp.38-50.

14 See D.N.Chester, Central and Local Government: Financial and Administrative Relations (1951).

to submit their schemes to central departments to make them eligible for grant at which point the latter had the power to approve, modify or reject. In addition, expenditure under such schemes was initially made by local authorities and central departments then had powers to check each item of local expenditure to ascertain whether it merited grant aid. Expenditure that was extravagant or did not otherwise accord with central aims could be punished by not being passed to rank for grant aid. By this means the content of local service development could be very closely controlled. To accompany the controls over local policies that were part of the percentage grant relationship central departments had further powers to use regulations to prevent or modify local spending that was not put forward for grant aid.

Local authority health care services were among many local services which received exchequer funding through the percentage grant subvention. The services for maternity and child welfare, tuberculosis, mental deficiency, blind welfare and school medical provision were each eligible for grants of 50%, and the services for venereal disease a grant of 75%. The department of central government responsible for local health care was the Ministry of Health, created in 1919. In addition to the administration of grant-aid relations the Ministry also required medical officers of health of county boroughs and county councils to submit annual reports on health services and standards in their areas, as well as

five yearly comparative reports on progress. County councils were further required to enquire in to provision by second tier authorities and report to the Ministry if there were any deficiencies. These methods provided the Ministry with further raw data with which to make critical assessments of local provision and formulate approaches to be taken towards different authorities in grant relations. It was generally through knowledge gained from inspection and such reports, and the informal exchange of information and advice, that the Ministry sought to ensure local provision in line with the Ministry's priorities rather than through resort to the more coercive powers attendant upon grant relations. In this sense the concept of partnership in central-local relations co-existed with a system of central control. However the relationship worked in practice, with regard to each local authority the overriding aim of the relationship was generally to achieve expansion, development and improvement in health care.[15]

It is important to recognise, however, that the Ministry of Health had wider responsibilities than local health care provision. The original impetus for its creation had been the unification of central government health care agencies. Thus in 1919 the Ministry also embraced the work of the health insurance commissioners for England and Wales, and the health care responsibilities previously held by the Home Office and the Board of Education. It also inherited from the

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15 Wilson, Municipal Health Services, pp.139-150.

former Local Government Board a general responsibility for overseeing local government and formulating policy on local government reform, as well, as we shall see, as central powers in relation to local poor law administration. The Ministry also acquired after the First World War responsibility for local housing provision and planning work.[16] As a result of its important responsibilities the Ministry was represented by a Minister in the Cabinet, and was administratively controlled by a permanent secretary. As a result of its varied responsibilities the Ministry itself was divided in to a number of separate divisions, headed by assistant secretaries. Major divisions included those for local government and public health. The public health division was then further divided in to branches, headed by principals. Each branch within the public health division related to an individual health service, its officers having a national remit. There was also a Welsh Board of Health, which was attached to the Ministry and answered to the Minister. In addition to divisional organisation local health care services also came under the scrutiny of the chief medical officer and his deputy, and the accountant-general's office, which was concerned with the finance of services.

It is also important to note that the Treasury, as defender of the exchequer, had an interest in the relations between the central departments and local

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16 See D.N.Chester (ed) and F.M.G.Willson, The Organisation of British Central Government, 1914-1964 (1968), pp.148-168.

authorities. Central grants to local government constituted a significant proportion of public expenditure by the 1920s. Consequently, in budgeting public expenditure the Treasury was keen to have some control over the level of grant-aid dispensed by all the spending departments, which included the Ministry of Health. This inevitably entailed inter-departmental relations at a central level which influenced the policies of the Ministry vis-a-vis local government and its provision of services, including those in relation to health. The Treasury was organised into only three divisions. These were the finance, supply and establishments divisions, the first two of which had interests in local government and individual service issues.[17]

By 1929, therefore, the structure and operation of local authorities as well as their responsibilities in relation to health care were clearly defined. Central-local relations were dominated by the percentage grant subvention, and in relation to health care were managed by the major department responsible for local government, which itself needed to have dealings on local government issues with other major departments of central government. How does a discussion of the poor law complete our understanding of local government and central-local relations before 1929?

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17 See H.E.Dale, The Higher Civil Service of Great Britain (1941), pp.1-24, Imperial Calendar and Civil Service Lists, and Public Record Office Current Guide, part 1, div 4.

(ii) THE POOR LAW AUTHORITIES AND CENTRAL GOVERNMENT

Under the 1834 Poor Law Amendment Act the country was separately divided in to 635 poor law unions, each union being further sub-divided in to areas of administration for boards of guardians.[18] The way in which poor law authorities functioned was in many ways a mirror image of the local authorities. The guardian franchise and the system of election were the same as in local authorities, with the important qualification of the position of the pauper.[19] Similarly, the guardians had the right to levy a local rate. Consequently, guardians had a democratic basis for autonomous policy making and an independent fiscal basis for expenditure decisions. They were also accountable to their local electorates. Poor law authorities did, of course, work in the same areas as other local authorities, and in county areas this led to some overlaps. Often rural district councils and boards of guardians were synonymous and elected at the same time. It was also commonplace for a borough or county councillor to be a guardian.

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18 Much of the following discussion is based upon S. and B. Webb, English Poor Law History, Part II, Volume II (1929), M.E.Rose, The Relief of Poverty, 1834-1914 (1972) and M.A.Crowther, The Workhouse System, 1834-1929 (1981).

19 See B.Keith Lucas, The English Local Government Franchise (1952) and footnote 4. For a discussion of the politics of pauper disenfranchisement either on its own or allied to Poor Law reform during the 1920s see A.Deacon and E.Briggs, 'Local Democracy and Central Policy: the issue of pauper votes', Policy and Politics (1973), pp.347-364.

The boards of guardians were all-purpose authorities for the provision for the poor, who could no longer support themselves and remained outside the otherwise general client remit of the local authorities. The poor included those able-bodied who were not in work as well as the non able bodied - the sick, aged, mentally deficient and infirm - and those whose circumstances forbade self-preservation - widows, deserted mothers and children. Under the 1834 Act it was intended that all provision should be made within specially created union workhouses and central government throughout the 19th century worked towards this aim. However, the permissive nature of the 1834 Act combined with local practice meant that the poor law by 1929 had developed in a more complex manner. The able-bodied unemployed were predominantly relieved through cash handouts outside the workhouse. Meanwhile in some areas the workhouse, renamed institution in the early 20th century, had developed in a mixed manner, catering for all categories of need under one roof. In other areas union institutions, with the encouragement of the pre-First World War Local Government Board, had developed as a series of specialist institutions, dealing for each category of need separately. The importance of this latter development must not be exaggerated. In 1929 some 60% of poor law inmates were still accommodated in the sick and general wards of general institutions. However, it did have a special significance for the development of local health care for the poor. It meant that to an increasing extent

poor law authorities developed separate infirmaries for the care of the sick, including specialist medical institutions for those suffering from such diseases as tuberculosis. At the same time, by 1929 poor law authorities had developed an extensive domiciliary medical service. With the expansion of guardians' work authorities generally created separate committees for dealing with out-relief and indoor relief. The administrative service for poor law authorities also expanded and the originally generic poor law official spawned a number of separate professions, including that of the poor law medical officer.[20]

The work of poor law authorities from the beginning aroused the interest of central government. The aims of the 1834 Poor Law Amendment Act were clear in directing poor law authorities to give a level of relief less eligible than the standard of living of those not reliant on the poor law. The reasoning was that this would stimulate paupers to seek to support themselves and take themselves off state reliance. Originally this centred on the provision of a deterrent system of discipline within the workhouse, but, with the continuation of out-relief, came also to include levels of cash relief beneath the lowest levels of wages of people in work. The move towards specialist institutional provision for the poor from the late 19th century onwards, however,

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20 See M.A.Crowther, The Workhouse System, 1834-1929 (1981), G.M.Ayers, England's First State Hospitals, 1867-1930 (1971) and B.Abel-Smith, The Hospitals, 1800-1948 (1951).

constituted an erosion of the spirit of 1834, in that it was recognised that provision for such categories of the poor as the sick should not be based upon the assumption that the pauper was responsible for his/her plight but that it should be of the greatest possible benefit. Indeed by 1929 the poor law had become a major hospital provider to rank alongside the voluntary hospitals, and some of the facilities offered by poor law hospitals ranked with the best to be found in the voluntary hospitals. Otherwise, the approach of central government up until 1929 remained broadly consistent with the original aims of 1834: to push poor law authorities into providing relief at the minimum level of state intervention. What this essentially meant was that the sick, amongst other categories of the poor, had gradually come to be perceived as deserving cases. Others, notably unemployed applicants for relief, who did not qualify for contributory unemployment insurance benefit, were still deemed undeserving and, therefore, were to be relieved in a deterrent manner outside the workhouse.[21]

Attempts at central control were not in any way connected with grant relationships, although the exchequer did provide subsidies for the payment of poor law officers' salaries. Rather central government had strong powers of inspection, and set national scales of out-relief which local guardians were expected to abide

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21 M.A.Crowther, The Workhouse System, 1834-1929 (1981), pp.88- 112. It should be noted that contributory national unemployment relief grew considerably after the First World War, leaving the poor law to cater only for those who were disallowed benefit nationally.

by. The 1926 Boards of Guardians (Default) Act and the subsequent supersession of a number of boards of guardians by central appointees is an indication of what could happen if localities went against national scales of relief. The central authority responsible for local poor law provision from 1919 was again the Ministry of Health, which had a poor law division. Before 1929 this division related to local poor law authorities entirely separately from the Ministry's relations with other local authorities. During the 1920s, whilst the division continued to encourage poor law unions to move away from general to specialised institutions, it is equally clear that the division embarked upon renewed efforts to keep out-relief at a deterrent level and that its chief officers were men imbued with the spirit of the poor law.

Consequently, in 1929 the popular perception that the underlying philosophy of the poor law remained that of deterrent provision to reduce state intervention and encourage self-help was as strong as ever. A stigma was still attached to the receipt of poor relief of any kind, and consequently even in well developed poor law infirmaries hospital beds lay empty. Hence, the system of poor law local government, central-local relations and their relationship with society at large were still highly distinctive set against that which pertained to the other major local authorities.

2. THE 1929 REFORMS

The poor law (health care) and exchequer grant reforms of 1929 revised these systems of local government, forms of service provision and central-local relations in a number of ways.[22] First, the poor law unions and their boards of guardians were abolished and their staff, institutions and responsibilities for the poor transferred to the county councils and county boroughs. In London they were predominantly transferred to London County Council. This meant that all the functions of elected local government were concentrated in the structure set up by the 1888, 1894 and 1899 local government acts. There was now only one system of elected local government in England and Wales.

The county and county borough councils were expected to submit administrative schemes of how they were going to discharge the transferred responsibilities within six months. The Poor Law was renamed public assistance and the local authorities were obliged to set up public assistance committees. There was considerable discretion over how public assistance committees were to be composed, as local authorities were allowed to co-opt up to a third of the members. The county councils were, however, obliged to create guardians' committees to be responsible for much of the detailed work of public assistance administration in each area of their counties. Members of the the guardians' committees were to be

22 Local Government Act, 1929. 19 GEO.5. CH.17.

chosen by county councils from amongst the members of district councils, although 1/3 were to be co-opted members. Whilst Part I of the Act laid down that some of the co-opted members must be women it was expressly stated that it would be desirable to include former guardians on both public assistance and guardians committees. However, whatever form of local organisation was created out-relief had to be administered under the terms of the 1927 Poor Law Act. Essentially, then, the Act envisaged no change in the operation of out-relief. In this respect the poor law was merely placed under new management, and did not represent a major service reform.

The reform of the poor law went much further with regard to provision for the non-able bodied poor. The Act encouraged local authorities to appropriate transferred services for the non-able bodied poor under other legislation. In this sense, the reform aimed at the break-up of the poor law, removing those services which had developed in a more progressive way in recent decades to the orbit of other committees of the county and county borough councils. Thus it was intended that local authorities provide former guardian infirmaries and health services through their public health committees under the 1875 Public Health Act, the 1913 Mental Deficiency Act, the 1918 Maternity and Child Welfare Act, the 1920 Blind Persons Act and the 1921 Public Health (tuberculosis) Act rather than under poor law acts. This would make the facilities and services available to everyone, rather than just the poor, and so unify local

health care provision. Thus, in sum, the local authorities were given the green light for the reorganisation of local health care under a philosophy of progressive expansion and improvement, free of the taint of the poor law. It is important to remember, however, that the legislation in respect to appropriation was permissive. Local authorities were not bound to use their new powers.[23]

With regard to local health care provision the reform spawned two further initiatives. First, it should be stressed that the transfer of poor law infirmaries meant that all public hospital provision was concentrated under the control of county and county borough councils. It was then considered desirable for these authorities to co-ordinate future hospital provision with the voluntary hospitals in their areas. To this end the local authorities were required to consult with committees set up by the voluntary hospitals over all future hospital planning. The reorganisation of local health care was, therefore, intended to embrace for the first time a relationship with local health care developed in the voluntary sector. Secondly, whilst the transfer of poor law medical services established the county boroughs as the only public health authority in their areas it left a more complex situation in the counties. Here the receiving authority was the county council, cementing its position as the major public provider. Whilst existing

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23 Local Government Act, 1929. Part I, sections 1-8. See also 6th schedule.

second tier authority responsibilities were not withdrawn it was clearly desirable to have a greater county council involvement in second tier provision if the county council was going to be able to secure a co-ordinated reorganisation of county public health care. To this end the Act gave county councils the power to contribute to second tier services, second tier authorities the power, by agreement, to transfer their services to the county councils, and the Minister the power, in the case of default by a second tier authority, to transfer a service to the county council.[24]

The reform of exchequer grants represented equally far-reaching change, which included reform of the central finance of local health services. The assigned revenues, the grants given in compensation for earlier partial derating of agriculture, several road grants and the percentage grants for maternity and child welfare, tuberculosis, venereal disease, blind welfare and mental deficiency were all abolished. At the same time agriculture became fully derated and industry and the railways 3/4 derated. Compensation for the discontinued grants and for derating valued at 1928-29 levels, were grouped together under a new grant, the general exchequer contribution, otherwise known as the block grant. Compensation for derating was valued at £24 million and for the discontinued grants at £16 million. These were to form fixed amounts in the grant for all time. However, from the beginning the block grant also included

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24 Local Government Act, 1929. Part IV, section 57.

an additional sum to ensure against local authority losers because of grant reform, initially set at £5 million. This amount was to vary in future years in accord with a minimum proportion formula. In 1930 the block grant was valued at £45 million and throughout the 1930s consistently represented 1/3 of all government grants.

The block grant was based on totally different principles to those of the percentage grants. First, the block grant was a general grant and was not related to specific services. Hence, local health care services, which would include any appropriated poor law services, for instance, had no ear-marked grant aid. As much of the block grant could be used on health as local authorities wanted. Similarly, block grant could be spent on any other service. This gave considerably more autonomy to local authorities in the spending of grant aid than had pertained hitherto. Secondly, the grant was to be fixed by central government for periods of years, initially in two periods of three and four years, 1930/31-1932/33 and 1933/34-1936/37, and thereafter for periods of five years. This meant that central grant was no longer determined by the spending levels of local authorities in individual years. Central government could fix the aggregate level of aid for years ahead at a time. The only variation in the quantity of block grant between grant periods was supplied by the working of the minimum proportion formula on the additional sum to be included in the grant. This stated that the proportion

which the block grant for any grant period bore to the the total amount of rate and grant borne expenditure in the penultimate year of the preceding grant period should never be less than the proportion which the block grant for the first period bore to the total expenditure in the first year of the first period. Essentially it was a device to keep the block grant reflective of the changes in financial burdens of local authorities.[25]

The third major innovation of the block grant was its method of distribution to local authorities. In sharp contrast to the specific percentage grant which was distributed to authorities on the basis of their level of expenditure, the block grant was to be distributed in relation to local authority needs. These were defined by a formula in which several factors for each local authority were taken into account: population, the number of children under five, rateable value, the proportion of unemployment and the population per mile of road. This needs-based weighted population formula was to be introduced gradually. For the first two periods up to 1937 the grant was to be 75% distributed in proportion to local expenditure and 25% formula distributed. It should be noted, however, that weighting of the unemployment

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25 See Local Government Act, 1929. Part VI, section 86. To illustrate how the minimum proportion formula worked in practice in helping to determine the aggregate level of the block grant:- The block grant in the first period was £43.5 million p.a. The level of rate and grant-borne expenditure for 1930-1931 was £188 million. The proportion of the former to the latter was 0.231. The rate and grant-borne expenditure for 1931-32 was £189.5 million. Hence the block grant for the second period had to be at least 0.231 of that figure.

factor was reduced from a multiplication of ten to six at the end of the first period. Between 1937/38 and 1941/42 the block grant was to be 50% formula distributed; 1941/42 and 1946/1947 75% and thereafter it was to operate on full formula redistribution.[26]

Provision was also made in the Act for anomalous results of the working of grant distribution. The Ministry of Health would be able to make additional grants to local authorities to ensure that all gained the equivalent of at least 1s rate per head p.a.. The Ministry would also be able to make supplementary exchequer grants to second tier authorities in the case of the county apportionment leading to grant losses, or to them becoming anomalous due to changes in rate poundage consequent upon the regrouping of second tier authorities. The Act provided for quinquennial censuses to ensure that the population factor in the block grant formula remained reasonably accurate. The Act also required an investigation, involving the representatives of local government, into the working of the whole block grant formula before the end of the second grant period.

Finally, the block grant was to be supplied in advance of expenditure. Under a specific percentage grant it was provided after expenditure and so allowed detailed checking of individual items of expenditure before grant was given. In being given in advance the block grant had to embrace a new form of central control in relation to the services affected, viz public health and roads, a

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26 See Local Government Act, 1929. 4th schedule.

more general form of control. In the case of public health the Ministry Of Health would henceforth carry out surveys of the whole scale and scope of the services provided by each local authority, with the sanctions in cases of deficient provision including the reduction or suspension of grant for the next grant period.[27]

The poor law and exchequer grant reforms, therefore, contained considerable potential for change. They included a reform of the structure of local government, placed the poor law under new local control and empowered local authorities to conduct a reorganisation of health care. The financial and administrative relations between central and local government were significantly altered. Ever since the reforms were enacted they have excited considerable discussion.

3. A RECEIVED ORTHODOXY

Three principal questions have been addressed in relation to the reforms: first, what were the origins of the reforms; secondly, why and how were they achieved; and, thirdly, how successfully were they implemented in the 1930s and with what implications? The basis of two orthodoxies in answering these questions were created immediately upon the Act's passing. A sympathetic and favourable approach was born in the Times editorial which stated in March 1929 that "the Local Government Act of

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27 Local Government Act, 1929. Part VI, sections 85-112. See also schedules 2nd to 5th.

1929 will take its place as one of the outstanding legislative achievements of the twentieth century".[28] By contrast, in the second volume of the second part of their epic history of the Poor Law Sidney and Beatrice Webb promoted an unsympathetic and critical approach with a denunciation of the Act on account of the problems it left unsolved and the new problems it created.[29]

In the period since 1929 there has been no comprehensive analysis of the poor law and exchequer grant reforms but such empirical analyses as have appeared predominantly follow the favourable approach sponsored by the Times. There are distinctive points of views within this literature but, more importantly, there are common assumptions, themes of analysis and conclusions. It is this literature which the thesis identifies as the predominant received orthodoxy on the 1929 reforms, and the remainder of this chapter will analyse its contents as a basis for further critical examination and empirical inquiry. Critiques offered by the Webbs and those writing after them will be taken up as a crucial part of the critical examination in chapter two.

(i) THE ORIGINS OF REFORM

With regard to the formulation of the reforms many historians have long been agreed that the basic origins

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28 The Times, 27.3.1929.
29 S. and B.Webb, English Poor Law History, Part II, Volume II (1929), pp.986-1023.

lie in the identification of a series of problems and their solutions in the years before the end of the First World War. First, it was perceived that the structure of local government needed reform. As early as 1888 it had been suggested by Joseph Chamberlain in the parliamentary debate on local government reform that it was anomalous and wasteful of administrative resources to retain ad hoc systems of local government, each with their own staffs and powers to levy rates. In 1902 the school boards were abolished and lost their functions to the local authorities. In 1909 both the majority and minority reports of the Royal Commission on the Poor Law suggested a similar fate for the poor law unions, the only remaining ad hoc authorities.[30] Their responsibilities should go to the county and county borough councils. The report of the Maclean sub-committee of the Addison Committee on Reconstruction after the First World War, published in 1918, came to the same conclusion.[31] A rationalisation of the local government structure was, therefore, recommended to overcome the problems of a multiplicity of local authorities.[32]

Further, in the years around the turn of the century, local government observers became concerned that poor law units of administration were too small anyway for the

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30 Report of the Royal Commission on the Poor Laws (cmd. 4499), PP (1909), xxxvii.
31 Report of the Maclean Committee (cmd. 8917), PP (1918).
32 C.H.Wilson, 'The Foundations of Local Government' in C.H.Wilson ed, Essays in Local Government (1948), pp.3-6; M.Schulz, 'The 1929 Local Government Act and subsequent legislation' in C.H.Wilson ed, Essays in Local Government (1948), p.67.

efficient and effective discharge of their duties. Socio-economic change, including population movements, had left many unions ill-equipped to meet the financial requirements of institutional provision and out-relief. If the poor law was to be administered in line with central requirements, the majority report of 1909 concluded, then it had to be removed to local authorities with larger areas and greater resources where the economies of scale could be realised. Hence the abolition of a separate system of poor law authorities and the placement of its responsibilities under the control of county boroughs and county councils was also argued for in 1909 on the grounds of a need to have the poor law administered by the largest units of local government.

In 1909 the force of this solution to the problems of unrationalised local administration and inefficient poor law provision was dented by a dispute within the Royal Commission over exactly what kind of poor law the county boroughs and county councils would administer. Whilst the majority report demanded the stricter application of the principles of 1834, the minority commissioners, led by the Webbs, wished for a completely new approach in which none of the poor were considered undeserving, and instead received more benevolent assistance appropriate to each applicant's needs, including assistance for the unemployed in finding work. In the 1918 Maclean Report, however, there was a unanimous comfirmation of the

majority report's position in this respect with regard to the treatment of the able-bodied poor.[33]

The problem of deficient local health care provision due to inadequacies in organisation was also isolated before the First World War. As early as 1869 Sir John Simon had lamented the existence of a multiplicity of public health care agencies and the poor co-ordination and wasteful duplication of services that resulted, and called for their replacement by a single public authority at both the central and local government level. Simon's views were echoed in the minority report of 1909, which suggested that all public services at a local level should be placed under the control of the county and county borough councils, as the basis of a co-ordinated state medical service. At the same time it was essential to place all poor law medical services under public health acts so as to free them from the stigma of the poor law. With the creation of a unified local service it would then be possible to develop a full-time, salaried state medical profession.[34]

In 1909 the majority of the Royal Commission on the Poor Law were against any breaking up of the poor law, and in 1911 the introduction of national health insurance appeared to provide an alternative model for the development of state health care. However, the Maclean

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33 Schulz, 'The Local Government Act of 1929 and subsequent legislation', in Wilson ed, Essays on Local Government (1948), p.69, pp.79-85.

34 See C.Webster, The Health Services since the War, volume I, Problems of Health Care: the National Health Service before 1957 (1988), pp.17-18.

Report in 1918 revealed that official opinion with respect to health care reform had moved along the lines set by Simon and the 1909 minority report, especially as the specialisation of Poor Law institutions had become the desired approach and it was wasteful that good hospital provision should remain unused due to stigma. Voluntary and national health insurance provision had their separate roles alongside which direct state provision would best be organised by a reform of the poor law and the unification of local health services under the largest areas of local administration, the counties and county boroughs, where again the greatest co-ordination of provision and the economies of scale could be gained. The logic of creating just one local health authority in each area was consistent with the creation of the Ministry of Health as the single central authority in 1919, and in the third reading of the Ministry of Health bill clear indications were given by the government that after careful consideration this had become the official approach.[35]

Consequently, by the end of the First World War certain problems concerning the structure of local government, poor law administration and local health care had been identified and an official consensus existed on their solution, embodied in the Maclean Report, which was to be put in to practice in the 1929 poor law (health care) reform. In relation to the debates over reform it

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35 See F.Honigsbaum, The Struggle for the Ministry of Health (1970).

should be stressed that a key theme was the isolation of the problem of relating function to area. Existing areas of administration were inappropriate to functional efficiency. The selection of the largest units of local government, the counties and county boroughs, as replacements would solve this problem.

Allied closely to the isolation of an area-function problem was the isolation before the First World War of an area-resource-function problem. This was rooted in the fact that there were enormous variations in population and wealth between different counties and different county boroughs. Consequently, there were great variations in rateable value. The problem was that a low rateable value tended to reflect both a high service need and a low capacity to meet it. This eroded the potential for local authorities to perform their functions effectively in the poorest areas. The form of central finance in aid of rates most commonly applied, the percentage grant, was perceived as perpetuating this problem. For grant aid being paid in proportion to local spending would assist most the wealthiest local authorities who could afford to spend most whilst having least need. Those authorities who could afford to spend least in the first place would consequently receive grant aid in proportion to their low spending. Central grants were, therefore guilty of not being directed at local authorities who needed them most. The end result was that the system of central-local finance in being regressive to need was breeding great variations in the

extent and quality of local service provision, which, as an interest in the maintenance of national standards developed, grew increasingly intolerable. The logical solution was for central government to abolish percentage grants and instead provide grants that were related to the needs of different local authorities.[36]

From the 1860s the percentage grants had also been perceived as being problematical for democratic accountability at a national level. Percentage grant aid was seen as being beyond the control of central government, thus undermining the national taxpayer. The local authority it was that determined its own levels of expenditure on grant aided services, and, since the amount of grant given in response was automatic, the local authority it was that determined the levels of central grant too. Not surprisingly the Treasury fought to regain control over what was becoming an increasingly significant item of revenue expenditure. The assigned revenues were introduced in 1888 for the very reason of trying to present an alternative source of finance to local authorities which could not undermine public expenditure control. However, as has been shown, the utility of percentage grants in central-local relations ensured that the trend towards their usage on new local services continued before the First World War. Clearly, an alternative source of national finance for local

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36 Schulz, 'The Development of the Grant System' in Wilson ed, Essays on Local Government (1948), pp.123-126.

services which gave central government control over its determination still needed to be found.[37]

The percentage grants also posed certain problems for democratic accountability at a local government level. Whilst they could be financially very helpful the extensive amount of detailed central control associated with their receipt was commonly perceived in local government as eroding local autonomy. Further, detailed checking of every item of expenditure was viewed universally in local government and by some in the central administration as being generally a waste of time better spent on more serious matters. Consequently, there was also a recognition a need for a system of central grants which gave local authorities greater freedom in their expenditure.[38]

In a number of ways then problems of the percentage grant had been perceived before the War. These problems and a general concern to put central finance of local authorities, which had developed in an ad hoc manner during the nineteenth century, on to a more systematic footing were acknowledged by the 1901 minority report of the Royal Commission on Local Taxation, which importantly was signed by the chairman, Lord Balfour of Burleigh. The report proposed a block grant to cover 50% of the recipient local authorities' total spending on national services. With respect to public health this intended to

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37 ibid, pp.125-132.
38 See G.Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance (cmd. 6453), PP (1976), p.109.

cover personal services but not sanitary and environmental services, which were deemed to be of purely local concern. The grant was to be calculated every ten years, according to a formula based partly on each local authority's actual expenditure but also on their relative needs, as measured by revenues and the ratio of population to ability to pay. The grant was then to be fixed until the next calculation. As a result, central government would gain the power to determine the overall level of central finance of local government, both local and central government would be relieved of the minutiae of itemised expenditure control, and a greater equalisation of resources between local authorities would be achieved. Here in embryo was the solution to the problems of the percentage grant system.[39]

Although the block grant principle had been advocated by only a minority of the royal commissioners in 1901 it received the most discussion in the ensuing years and was largely endorsed by the Departmental (Kempe) Committee on Local Taxation in 1914.[40] A bill, based on the Kempe Report, was prepared in 1914 but had to be dropped because of the outbreak of War. Yet, the the block grant had been firmly established as a solution to all of the perceived problems of percentage grants. Consequently, in a manner similar to the debate over poor law (health Care) reform, the problems of exchequer grants had been

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39 Final Report of the Royal Commission on Local Taxation (cmd. 638), PP (1901).
40 Report of the Departmental (Kempe) Committee on Local Taxation (cmd. 7315), PP (1914).

isolated before the War and an official consensus existed for their solution, which again was to be reflected in the legislative changes of 1929.

A discussion of such problems and these solutions forms the basis of much historical analysis of the origins of the 1929 reforms.[41] Implicitly, it suggests a highly rationalist approach to seeking out reforms to meet the problems of modernity. For it is demonstrated that the reforms were conceived on the basis of work by key actors from both outside and inside government, working on a variety of royal commissions and committees, gradually producing agreed policy.

It is then the common practice of historians to find more contemporary origins for the reforms in the implications of the economic slump of the 1920s, although their analysis suggests merely the exacerbation of the problems already outlined. High unemployment threw large numbers onto the Poor Law. This had two results. First, many poor law authorities complained of an inability to meet the cost of their clientele. Secondly, a minority of authorities, notably Poplar, met the challenge of high unemployment with outdoor relief which exceeded relief scales laid down by the Ministry of Health. A large number of poor law authorities were, therefore, hard pressed to or disinclined to relieve unemployment in line with central government requirements. This was a clear

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41 See, for example, C.L.Mowat, Britain Between the Wars, 1918-1940 (1955), pp.340-342, M.Bruce, The Coming of the Welfare State (1965), pp.224-228 and B.Keith-Lucas and P.G.Richards, A History of Local Government in the Twentieth Century (1978), pp.88-90.

re-incarnation of the area-resource problem compounded by what was perceived centrally as maladministration.[42] At the same time the slump made the lack of central control over grant aid all the more intolerable, and the inequitable nature of grant aid distribution an even greater source of complaint from those areas suffering most from the slump.[43] This context served to make the reform of local government the subject of considerable public discussion and controversy during the 1920s.[44]

It is argued by a number of historians, however, that this more controversial public aspect to the problems of local government and central-local relations, whilst making reform more politically possible, did not affect the substance of proposals for local government reform. This was determined by the earlier debate.[45] Within the post-War Ministry of Health civil servants and ministers worked without controversy on the elaboration of long-term plans for reform based upon the reform consensus which had been agreed by the end of the First World War.

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42 See, for example, A.J.P.Taylor, English History, 1914-1945 (1965), pp236-238 and Keith-Lucas and Richards, A History of Local Government in the Twentieth Century, pp.88-90.

43 See J.H.Warren (revised by P.G.Richards), The English Local Government System (1965), pp.65-67 and M.Newcomer, 'English Local Government Under the Local Government Act of 1929', Political Science Quarterly, 51, 1936, pp.538-568.

44 See B.B.Gilbert, British Social Policy, 1914-1939 (1970), pp.203-235 for a full sense of the controversy. It should be noted, however, that Gilbert makes a critical rather than a favourable interpretation of the formulation and implementation of the poor law (health care) and exchequer grant reforms. See chapter two.

45 See, for example, Rhodes in Appendix Six of the Report of the (Layfield) Committee of Inquiry into Local Government Finance

It is these plans which came to fruition in 1929 after a long battle to gain their achievement in a pluralist environment of inter-departmental relations and high politics. The chronology of the development of these plans is generally divided into two periods.

(ii) THE MINISTRY OF HEALTH PLAN

Analysis of the post-War bureaucratic input into the reform process remains scant but Rhodes has established conclusively that the original authorship of detailed reform proposals lay with the Ministry of Health. Officials worked on a plan for local government reform soon after the Ministry was created. An internal committee on health organisation and poor law reform put together a reform of the poor law and the organisation and functions of local authorities on the basis of the Maclean Report, and as a result of the Ministry's special position as the department with a general responsibility for the relations between central and local government, also worked on a reform of exchequer grants based on the pre-war advocacy of block grants.[46] The detailed work on a block grant reform was undertaken by Ernest Strohmenger, the accountant-general, whose conclusions were immediately endorsed by the permanent secretary, Arthur Robinson, and other senior officials, for the main

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46 Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry into Local Government Finance, pp.109-110.

reason that it would allow greater uniformity in service provision between local authorities.[47]

The committee's proposals came together in 1921 in a draft Cabinet memorandum for the then Minister of Health, Alfred Mond. The content of the proposals was basically that which was to appear as the main substance of parts I and VI of the 1929 Act, including a block grant limited to the replacement of the assigned revenues and only the percentage grants for which the Ministry was responsible, ie the health grants. The memorandum stated that greater local autonomy was desirable in itself but that this and the block grant's redistributive principle would also be beneficial in gaining the support of local authorities for the transfer of Poor Law functions.[48] Rhodes suggest that this was good thinking for at the end of the War the Association of Municipal Corporations (AMC), representing the county boroughs and non-county boroughs, and the County Councils Association (CCA) wanted more financial aid and greater freedom from central control above all else.[49] Stacey casts some doubt on this, suggesting that many local authorities remained in favour of percentage grants. Nevertheless, the Ministry's perception of local authorities views on grants remained crucial to the logic of the memorandum. The Ministry further expected

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47 S.Stacey, 'The Ministry of Health:ideas and practice in a government department' (unpublished DPhil thesis, Oxford University, 1985), p.227.
48 For a copy of the Mond Memorandum, May 1921, see PRO HLG 68/25: Miscellaneous unallocated papers on Poor Law reform, 1919- 1925.
49 Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance, pp.109-110.

Treasury support as the block grant gave central government the power to fix aid ahead of local expenditure.[50]

The main text of the 1929 reforms had, therefore, been established uncontroversially within the the Ministry of Health by 1921. Rhodes and Stacey suggest that the Mond memorandum then became an established Ministry view. Stacey mentions some rather contradictory evidence of Stuchbury and De Montmorency, officers in the public health division, arguing for percentage grants in their evidence to the Geddes Committee. However, he firmly locates this as being outside the main lines of policy development within the Ministry. The Ministry was united in its intention to see the Mond memorandum through to the statute books.[51]

However, the Ministry's hopes ran aground on three rocks between 1921 and 1924. Rhodes reveals that the first obstacle was the financial crisis that overcame government in 1921. The crisis led in the first instance to the non-submittal of the Mond memorandum to Cabinet, and later to the creation of the Geddes Committee, which in the search for immediate economies in public expenditure steered the Ministry of Health in to a short-term policy of grant rationing and away from any long-term service or grant reform.

The second problem was that the Geddes Committee came out in favour of the immediate abolition of all

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50 Stacey, thesis, pp.305-306.
51 ibid, p.288-289.

percentage grants and their replacement by a block grant to cover all local authority aided services, thus giving central government complete control over the level of support, rather than the partial support offered by the Ministry of Health scheme. The Ministry of Health, as Rhodes showed, whilst in support of a block grant reform saw it as an inter-related package with poor law reform. Therefore, officials did not want exchequer grants reformed in isolation. At the same time the Geddes recommendation confronted the ministers of other spending departments dealing with local authority services with a block grant reform. The government appointed a committee under the chairmanship of Lord Meston to hear the views of all concerned. The Meston Committee failed to make a report and indeed petered out amidst the conflict between central departments over the block grant issue. The Treasury came out strongly in favour of a block grant to cover all local authority services, the other spending departments remained solidly opposed. The Ministry of Health plan now lay in no mans land. It advocated some block granting but fell well short of the comprehensive block grant which the Treasury wanted.[52]

It is possible that the Ministry's plan could still have been championed by an energetic minister in Cabinet for, as Leland demonstrates, all of the main political parties voiced themselves in favour of implementing the Maclean Report in 1918. There was, thus, a political

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52 Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance, pp.110-112.

consensus on reform, which mirrored that which existed within Whitehall.[53] However, the third and conclusive reason why the Ministry reforms remained on the shelves was the lack of political leadership as ministers came and went with rapid changes of government. Stacey demonstrates how John Wheatley, the Labour Minister of Health in 1924, attempted reform but failed simply because his government lost office before he could formulate a bill. In late 1924 the Ministry's 1921 plan, therefore, remained on the shelves.[54]

(iii) THE ACHIEVEMENT OF REFORM

At this point Neville Chamberlain arrived at the Ministry Of Health and the struggle to bring the Ministry's inter-related poor law (health care) and partial block grant reform to fruition gained new impetus. The interest of historians in the detailed evolution of the reforms also picks up. Principally Chamberlain is credited with a bureaucratic approach to the problems of public administration. He combatted the perceived mal-administration of poplarism with a series of measures between 1926 and 1928, and embarked upon the more long-term solutions to the problems of the Poor Law, local health care and central-local financial relations on the

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53 J.Woodmansee Leland, 'Neville Chamberlain and British Social Legislation, 1923-1929' (unpublished PhD. thesis, Ohio State University, 1970), p.277.
54 Stacey, thesis, pp.228-229.

basis of the Ministry of Health reform plans.[55] The more detailed analyses stress the energy with which he did this. Stacey joins Feiling, Dilks and Leland in characterising Chamberlain as an altruistic politician prepared to see complex, but necessary, reforms through and as both a visionary and a practical social reformer.[56] The role played by Chamberlain in the achievement of the reforms is constructed as follows.

After serving briefly at the Ministry of Health in 1923, it is argued, he specifically asked to return in 1924 rather than take the more prestigious position of Chancellor of the Exchequer. Dilks suggests that he did so out of a profound desire to carry important social reforms for the good of the people, which were based on the reform of local government. In particular, he sought the removal of health care from the poor law, co-ordination of local health services, and from a very early stage a partnership between the voluntary hospitals and local authorities. The block grant he perceived as an ideal way of helping the necessitous areas. The phenomenon of poplarism, in which some, predominantly Labour, boards of guardians gave more generous levels of out-relief than the Ministry's poor law division desired, did nothing to influence Chamberlain's basic commitment

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55 Ibid, pvii, Bruce, The Coming of the Welfare State (1965), pp.224-228, Taylor, English History, 1914-1945 (1965), pp.236-238, Keith-Lucas and Richards, A History of Local Government in the Twentieth Century (1978), pp.43-45.
56 Stacey, thesis, pp.146-152; K.Feiling, The Life of Neville Chamberlain (1946), pp.126-128; D.Dilks, Neville Chamberlain, Volume One: Pioneering and Reform 1869-1929 (1984), p.405; and J.Woodmansee Leland, thesis, p.278.

to move the poor law to larger county borough and county areas in which the financial difficulties of the poor law could be solved by wealthy areas subsidising their poorer neighbours. Nor was he afraid of the potential root and branch opposition of the boards of guardians to their abolition.[57]

In addition, Chamberlain had the necessary expertise, which other ministers had lacked, to understand the complexities of reform. This was based on personal service in local government and work in relation to voluntary hospitals. He won the respect of officials at the Ministry of Health and, whilst the local government reforms were based on Ministry-derived plans, they recognised that Chamberlain made the further important contribution of placing local government reform within a series of other reforms with a unifying vision. In the four year programme which he presented to Cabinet within two weeks of taking office, Chamberlain not only included the poor law (health care) and partial block grant reform but also a rating and valuation reform. This was a necessary pre-requisite to poor law reform, as it intended to remove rating powers from poor law officers, as well as being a necessary pre-requisite to block grant reform, as it provided for the greater uniformity essential to making rateable value a reliable indicator of need in a formula. He also included a reform of pensions, which would take many of the elderly out of the

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57 Dilks, Neville Chamberlain, Volume one: Pioneering and Reform 1869-1929, pp.405-420.

poor law, thus making out-relief by local government in the long-run much more manageable.[58]

Chamberlain's credentials as Minister of Health gained the immediate go ahead from Cabinet to develop the poor law (health care) reform and the Ministry's partial block grant reform in detail. Over the next four years Ministry officials were responsible for the development of detailed proposals, including identifying the factors which best reflected local authority needs for the block grant formula. The Royal Commission on Local Government, which sat between 1923 and 1929, is assumed by Schulz to have had considerable input in to the development of the reforms as well but this is repudiated by Stacey and Leland. The reforms were specifically left out of the terms of reference of the Commission so as not to further complicate the development of reform. Chamberlain merely used the Royal Commission as a sounding board for some ideas. Rhodes does not even mention the Royal Commission in his analysis. Instead, Ministry officials quietly went about the uncontroversial completion of reforms which they had first evolved after the War.[59]

Rhodes notes, however, how Chamberlain involved the local authorities in deliberations over reform from the beginning in an effort to gain reform by consent. Negotiations in 1925 led to certain concessions,

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58 Dilks, Neville Chamberlain, Volume One: Pioneering and Reform, 1869-1929, pp.413-420; Stacey, thesis, pp.188-198.
59 Schulz, 'The Local Government Act of 1929 and Subsequent Legislation' in Wilson ed, Essays on Local Government, pp.72-74; Stacey, thesis, pp.265-266; Leland, thesis, pp.327-328.

including making the first grant period only three years rather than five years, so as to make the process of change more gradual. Furthermore, Chamberlain quickly saw how essential it would be to include an additional sum in the grant so as to fully placate local authority worries that they would lose financially by a grant reform and taking on more service responsibilities . By November 1926 policy development had proceeded swiftly enough for Chamberlain to go to Cabinet asking for sanction to bring in a bill in the next session of Parliament.[60] However, three issues are highlighted by Rhodes as causing further delays in reform.

First, the Conservative election victory in late 1924 had brought Lord Eustace Percy to the Board of Education. In 1925 Percy issued a circular to local authorities announcing that the Board had changed its policy on grants and would introduce its own block grant. The circular caused major political controversy and was withdrawn, but in 1926 Percy was still pursuing the issue. The Cabinet responded by creating a new committee, this time of officials, under the senior Treasury official, Sir George Barstow. The Barstow Committee merely served to reopen the divisions between the Treasury and the spending departments. The Home Office, the Scottish Office, and even Board of Education officials argued against block granting. The Treasury, meanwhile, played again for a comprehensive block grant.

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60 Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance, p.113.

In Cabinet Winston Churchill, who had become Chancellor of the Exchequer in 1924, argued strongly for a comprehensive block grant which precluded Chamberlain's limited scheme. Churchill further refused a step-by-step approach of introducing a limited block grant with the poor law reform, which could then be followed by the further block granting of grant-aided local services. In February 1927 the Cabinet convened a further committee, this time of ministers. However, Churchill remained immovable and in 1927 Chamberlain was limited by Cabinet to discussing only poor law reform with the local authorities. The Ministry of Health's block grant reform was effectively sidelined again.[61]

Chamberlain and the Ministry of Health, of course, viewed poor law and its grant reform as an inter-related package. The obstruction of the grant reform threatened the whole reform. Further, Rhodes also draws attention to the fact that the Cabinet was decidedly lukewarm on poor law reform in itself. In February 1927 reform was postponed to the autumn, at which time it was postponed again until 1928, and Chamberlain feared for its eventual fate. The obstacle to poor law reform in itself came from the rural guardians, represented by rural Conservative backbenchers. They seriously resented their abolition and opposed Chamberlain's proposed reforms. However, Dilks highlights Chamberlain's major political success in developing the reform with the consent of the guardians as well. Importantly, he made the concessions

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61 ibid, pp.113-114.

that in the administration of public assistance by county and county councils former guardians could be co-opted, and in administration within counties devolution to guardians committees would be made. The guardians were content that their experience would not be completely discarded whilst Chamberlain secured his major aim of having the finance of administration over larger areas. Hence, by 1927 Chamberlain had removed one of the obstacles to reform. The major hurdle still left was the Treasury's continued commitment to a comprehensive block grant or none at all.[62]

At this point Winston Churchill introduced his derating policy, the deliberation of which further threatened reform. A further cabinet committee was appointed in January 1928 which became a new arena for Churchill and Chamberlain to come into conflict. Chamberlain opposed derating and the two still disagreed over the extent of block granting. The result of this conflict was, however, to bring about eventual Cabinet acceptance of Chamberlain's reforms. Schulz and others have suggested that Cabinet essentially backed derating as a major economic policy initiative in the build-up to the 1929 election, and that Chamberlain's reforms merely got in to the 1928 Local Government Bill, hanging by derating's shirt-tails.[63] However, Dilks is to the fore

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62 Dilks, Neville Chamberlain, Volume One:Pioneering and Reform 1869-1929, pp.513-514.
63 Schulz, 'The Local Government Act of 1929 and Subsequent Legislation' in Wilson ed, Essays on Local Government, p.68. See also M.Gilbert, Winston S.Churchill, Volume Five, 1922-1939 (1976).

in suggesting that the Churchill-Chamberlain conflict was resolved through a brilliant compromise engineered by Chamberlain. Despite his overall opposition to derating, Chamberlain accepted it. Even then he won important revisions which ensured that important principles of local government were not contradicted. For instance, Churchill's original scheme for the complete derating of industry was converted to one of 3/4 derating so that an industrial interest in local government would be maintained, and any notions of local sources of income being collected by national government were successfully opposed.

Chamberlain also then won Cabinet support for the local government reforms. He did so precisely because the rest of the Cabinet recognised Chamberlain as the only member of the Government who understood the complex questions involved and could ensure that derating was made a practicable policy. Furthermore, in order to win Chamberlain's support for derating Churchill and the Treasury quietly dropped their advocacy of a general block grant, in favour of Chamberlain's partial scheme, allied to poor law reform. It then became sensible to integrate the compensation for derating in to the Ministry's partial block grant. Derating was announced in the 1928 budget speech and in June Chamberlain finally introduced a white paper on the reform of local government and central-local financial relations, which

was still largely derived from the Mond Memorandum of seven years previous, only now incorporating derating.[64]

All that remained then was to fine tune the reform with the local authorities. Dilks suggests that this was the climax of Chamberlain's major achievement of gaining reform by consent. He shepherded the local authority associations in to agreement with concessions which whilst meaningful did not undermine the basic principles of the reforms. The gradual introduction of the block grant was assured by having the first grant period over three years and the second over four years. The full introduction of the formula basis to the grant was delayed until 1947. Chamberlain also assured the local authorities that the new grant relations would embrace considerably greater local autonomy in spending decisions. Finally, after the 2nd reading of the Local Government bill in November 1928 the associations still remained anxious about the extent of compensation for grant and rate losses, and the working of the block grant formula. In particular, the AMC and CCA wanted compensation for derating separated from the block grant. Yet, despite much public dissent, Chamberlain used his friendship with Alderman Williams of the AMC to get both the AMC and the CCA to drop opposition in return for the guarantee that, as a result of the inclusion of an additional sum in the grant and the provision for additional grants, no local authority would lose by the

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64 Dilks, Neville Chamberlain, Volume One:Pioneering and Reform 1869-1929, pp.546-557.

grant reform in the first five years. At the same time provision was made for a five year census and a formula investigation. Such concessions cost little and represented no erosion of the main thrust of the reforms.[65]

Finally, then, solutions to problems of local government, central-local relations and economic and social policy, which had all been identified by the end of the First World War, were achieved as a set of long-overdue reforms in the 1929 Act.[66] Several broad conclusions on policy development during the 1920s can be drawn from the historical work discussed. Officials at the Ministry of Health had played the key role in the detailed development of the reforms in a manner which suggests the neutral observance of the 1918 reform consensus. Neville Chamberlain had then played the key role in politically delivering the reforms in a style which could be characterised as that of the liberal hero of social reform. He had also delivered reform in a way which ensured consent from the many interests who at various times obstructed reform. By 1929 the major

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65 Dilks, Neville Chamberlain, Volume One:Pioneering and Reform 1869-1929, pp.568-571. Dilks' account is based directly upon Chamberlain's view of the level of consent achieved and the relative significance of the concessions made. See Neville Chamberlain papers, NC 2/22, political diary, 24.2.1929. where Chamberlain writes "The crucial part was the negotiations with the L.a.s and thanks to careful handling they were shepherded in to asking for concessions on the lines on which I had always contemplated that I might meet them safely...they were of such a character as enabled them to accept and members of the party to feel that they could go to their constituents with confidence".

66 Stacey, thesis, p.270.

departments of central government were content. The Ministry of Health had achieved the realisation of the Mond Memorandum. The Treasury, whilst preferring a general block grant had achieved a move towards the goal of greater central control of grant aid, and implemented derating. The other spending departments had been left content with their systems of percentage grants. The Conservative party enthusiastically acclaimed the 1929 reforms as a great legislative achievement, and Dilks claims that Parliament as a whole, despite public Labour Party opposition, received Chamberlain's two and a half hour speech at the second reading of the bill with great admiration.[67] Even the Webbs, whose criticism will be examined in the next chapter, have been portrayed as enthusiastic endorsers of the abolition of the boards of guardians.[68] Further, it has been suggested that certain critical vested interests were successfully mollified. For example, the rural guardians, who were being abolished and were, therefore, deeply resentful were promised a role in the new system of public assistance; and the county and county borough councils, who had voiced many criticisms, were hopeful that the reforms would provide a permanent solution to the problems of inadequate resourcing, service co-ordination

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67 Dilks, Neville Chamberlain, Volume One:Pioneering and Reform 1869-1929, pp.571-574.
68 See Bruce, The Coming of the Welfare State (1965), p.226. See also N. and J.Mackenzie, The Diary of Beatrice Webb, Volume Four, 1924-1943, The Wheel of Life (1985), p.153.

and over-rigid central control.[69] By definition, if such problems of local government were solved then the reforms also stood as major social reforms in the wider interests of the people, especially those living in poorer areas of the country. In short, it appeared that the plurality of interests and actors who were involved had been appeased in the 1929 reforms: the ultimate hallmark of a successful reform in a democratic society. There was, as a result, considerable contemporary optimism for the future, an optimism which informs the concluding remarks of many of the historians cited.[70]

(iv) THE IMPLEMENTATION OF REFORM

Historians have not on the whole researched the implementation of the 1929 reforms in any great depth. Some research on the implementation of the block grant suggests considerable success. It is implicitly suggested by Rhodes that the Treasury was pleased with the grant as a means of controlling Exchequer aid to local authorities, thus safeguarding the independence of the taxpayer, for in a 1932 inter-departmental conference the Treasury once again pressed hard for a general block grant to cover all grant-aided local services. It was thwarted once more by the arguments of the Home Office in

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69 Wilson, 'The Foundations of Local Government' in Wilson ed, Essays on Local Government, p.6.
70 For the most recent overview endorsement of the favourable approach to the origins and achievement of and the reception given to the 1929 reforms see J.Stevenson, British Society, 1914-1945 (1984), p.301.

favour of the continuance of percentage grants, and had to accept the impossibility of finding a simple formula for block granting education because of the enormous complexity of the variations in costs of providing education in different areas. Yet, it is suggested that the Treasury never fully abandoned the potential of further block granting before the Second World War.[71]

With regard to directing grant aid at the poorer local authorities Rhodes further suggests that the "block grant had some effect in giving help to these areas but did not sufficiently offset the disadvantages which they suffered".[72] The decisive factor limiting the block grant's ability to help the necessitous areas was the recession which set in in these areas in 1929 and lasted until the mid-1930s, and in some areas until the Second World War. Service needs and, consequently, the demands on local expenditure, rose to levels not forecastable in the framing of the block grant reform in 1929. Hence, as Newcomer and Stacey point out, any failure of the block grant formula to distribute grant aid according to local need in the 1930s was more to do with the recession than any inherent deficiencies in the reform itself.[73]

Schulz further argues that the detailed investigation of the block grant formula, conducted between 1935 and

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71 Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance, pp.116-117.
72 ibid, p.117.
73 M.Newcomer, 'English Local Government Under the Local Government Act of 1929', Political Science Quarterly, 51, 1936, pp.563-564. For a lengthier treatment with similar conclusions see M.Newcomer, Central and Local Finance in Germany and England (1937). Stacey, thesis, p.318.

1937 by the Ministry of Health and the local authority associations, with co-opted representatives of the necessitous areas, revealed that on the whole the formula had worked generally in accord with central aims in the first two block grant periods. It had not, however, fully met the needs of necessitous areas because increases in population allied to a decline in the number of children under the age of five and a general increase in rateable values had tended to increase the proportion of grant attracted to the basic formula factor, ie population. This worked to the advantage of the wealthier local authorities. The reduction in the weighting of the unemployment factor between the second and third grant periods, which had been further intended in 1929, was not likely to assist the situation.

The formula investigation did, however, work to solve this problem. Forty modifications were tested, including the usage of a variety of alternative factors. This resulted in the adoption by the Ministry of Health of test D3 modified, by which there was an increase in the unemployment weighting for necessitous areas and an increase in the weighting of the population sparsity factor for some rural counties. Even where the block grant was found wanting, therefore, central government moved to make amends, although further moves to revise the distribution of grant among second tier authorities ran aground on a lack of local consensus.[74]

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74 Schulz, 'The Development of the Grant System' in Wilson ed, Essays on Local Government, pp.136-142.

A further measure of the general success of the block grant can be found in the report of the Ray Committee in 1932, in which the local authority representatives called for more block granting on the grounds of its beneficial effects for the finance of local government and local autonomy.[75] By 1939, Schulz authoritatively asserts, the block grant had become "an essential part of local finance". The only consistent complaints in relation to the financial reform of 1929 were directed at derating, for which local authorities considered they had received inadequate compensation.[76]

Successful implementation of the poor law reform has been less obvious to historians. Many local authorities found the cost of public assistance more than they could bear and lobbied the Royal Commission on Unemployment Insurance for the removal of the responsibility to national government. In addition, the phenomenon of poplarism re-occurred in the administration of out-relief by some county boroughs. Yet, the effect of the recession may also be chiefly held responsible for making the cost of public assistance prohibitive in poorer areas or for making the administration of out-relief in to a matter of conflict between central and local government. In addition, there were compelling arguments in central government in the early 1930s in relation to the administration of the unemployment insurance scheme and

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75 Report of the (Ray) Committee on Local Expenditure (England and Wales) (cmd. 4200), PP (1932).
76 Schulz, 'The Development of the Grant System' in Wilson ed, Essays on Local Government, p.142, p.160.

transitional payments, which had been placed under public assistance committee administration in 1931, as to why the relief of unemployment should be placed on a totally national footing. It is for these reasons, then, rather than inherent defects in the ability of county and county borough councils to administer public assistance, that responsibility for the unemployed was taken away from public assistance committees by the 1934 Unemployment Act and placed under the newly constituted Unemployment Assistance Board.[77]

Research also shows problems in the successful implementation of the 1929 Act as a health care reform. Abel-Smith and Webster, for example, highlight the enormous variations in health care spending and standards between different local authority areas.[78] In his pessimistic analysis of health care standards in the 1930s Webster argues that in the poorer areas, most affected by unemployment, resources were simply too low to support adequate provision.[79] Abel-Smith reveals the highly limited extent to which county and county borough councils appropriated poor law infirmaries under public health acts. By 1938 only 109 hospitals had been

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77 R.Lowe, Adjusting to Democracy, The Role of the Ministry of Labour in British politics, 1916-1939 (1986), pp.132-167.
78 Abel-Smith, The Hospitals; Webster, The Health Services Since the War, Volume One, Problems of Health Care:the National Health Service Before 1957.
79 ibid, p.8. See also C.Webster, 'Healthy or Hungry Thirties', History Workshop Journal, no.13, 1982, pp.110-129. For a feminist interpretation of the implications for local health standards of insufficient resourcing see Lewis, The Politics of Motherhood, Child and Maternal Welfare in England, 1900-1939 (1980), p.17.

appropriated nationwide and nearly 1/3 of all public hospital beds were still to be found in mixed public assistance institutions administered by public assistance committees. In addition, whilst virtually all local authorities consulted voluntary hospital committees over hospital planning, only in some urban areas, chiefly Birmingham, Liverpool, Plymouth and Bristol, did this result in substantial rationalisation.[80]

Strong evidence has, therefore, been presented to support the view that the block grant did little to enhance local health funding and services and that the local authorities responded to their greater financial autonomy and the permissive provisions of the Act, empowering the unification and co-ordination of public health services, with an apathy which only served to exacerbate deficiencies. The difficulty remains, however, of evaluating the primacy of these potential reasons for deficient local health care. This is born out, for example, by Bryder's study of local tuberculosis provision.[81] Whatever the cause of deficiency Wilson further suggests that the Ministry of Health power to reduce grant in the case of deficiency or extravagance was an empty one. It was never used because of problems for the Ministry of Health in defining whether services were adequate in relation to local needs, and in relation to cases of high expenditure it "would arouse great

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80 Abel-Smith, The Hospitals, pp.368-383.
81 L.Bryder, Below the Majic Mountain, A Social History of Tuberculosis in Twentieth-Century Britain (1988), pp.93-96.

resentment, and, in the case of a large local authority, a considerable political storm".[82]

Historians have, however, presented further evidence which lays the basis of a more optimistic interpretation of the implementation of reform. Schulz suggests that the introduction of non-specific grant-aid did not overall have an adverse effect on local health expenditures. Expenditure on maternity and child welfare, the most recently initiated health service, which logically still needed the stimulus of the specific percentage grant, flattened out during the early 1930s, but picked up from the mid-1930s once the chief medical officer of the Ministry of Health had drawn attention to inadequacies in some areas. Further, local authority expenditure on hospital provision, which included non-grant aided capital expenditure rose spectacularly during the 1930s despite government economy campaigns.[83] Winter's view, based on official mortality statistics, that health standards rose during the inter-war period in all but a few pockets of recession lends further credence to an optimistic portrayal of local health care development.[84]

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82 Wilson, Municipal Health Services, pp.150-151.
83 Schulz, 'The Development of the Grant System' in Wilson ed, Essays on Local Government, p143.
84 J.M.Winter, 'Infant Mortality, Maternal Mortality and Public Health in Britain in the 1930s, Journal of European Economic History, Volume 8, 1979, pp.439-462. See also J.M.Winter, 'The Decline of Mortality in Britain 1870-1950', in T.Barker and M.Drake (eds), Population and Society in Britain 1850-1980 (1982), pp.100-120, and J.M.Winter, The Great War and The British People (1986).

It is also possible to cast doubt over whether those failures which did occur were due to integral weaknesses in the 1929 legislation. It is true that poorer local authorities lacked the resources to develop spending in the 1930s and that the redistributive quality of the block grant had intended to make good such deficiencies. However, as it has already been argued, the desired effects of the block grant were eroded by the unforecastable recession. As Wilson commented in 1946, "it has unfortunately been the case that for many local authorities in the years before the War the block grant was swallowed up by the mounting cost of poor relief". He also suggested that even authorities who were otherwise lukewarm on health service development could argue a lack of resources even if they had not so been.[85]

Abel-Smith is also careful to discuss the many varied reasons for local failures on appropriation. First, many of the institutions inherited from the poor law unions were mixed or built many years before, or both, and were, therefore, unsuitable for appropriation as general hospitals. This explained why county council appropriation, other then in London, Surrey and Middlesex was so low, and county borough appropriation so patchy. The local authorities after 1929 had to improve from a considerable state of backwardness, which was no fault of their own. In addition, in trying to do so, they were hampered by the economy philosophy in government in the early 1930s, which bode against the kind of expenditure

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85 Wilson, Municipal Health Services, p.150.

necessary for rebuilding, staffing and equipment. Many local authorities also became confused as to whether the recovery of costs from patients would be as easy under public health acts, and so out of a policy of safety first continued to prefer to register patients under poor law acts. Inadvertently, the provisions in the 1929 Act allowing continued service by former guardians as co-opted members also held back development. On many public assistance committees they exercised a decisive influence in keeping the most interesting element of their work under their control rather than allowing it to go to public health committees. Abel-Smith also suggests that the limited implementation of genuine co-ordination of hospital planning between local authorities and voluntary hospitals as often as not ran aground on the apathy of voluntary hospitals. By 1934 only in 83 out of 146 local authority areas had the voluntary hospitals set up committees for consultation.[86]

There were, therefore, many mitigating factors in the 1930s which can explain why the grand hopes for local health care development and co-ordination could not be attained in the short-term. Further, Abel-Smith concludes that the health care reform of 1929 was above all an experiment in local independence. Whatever defects in the 1929 approach to reform were detected they could be used to make improvements in the future. Indeed, there is ample evidence to show that the Ministry of Health kept faith with the county and county borough

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86 Abel-Smith, The Hospitals, p.368-383.

councils as the major local health authorities, and worked to expand their range of provision after 1929. Under the only two major pieces of health legislation in the 1930s, the Midwives Act of 1936, and the Cancer Act of 1939, they were again made the responsible authorities. With sophistication of the block grant formula and its greater role in the distribution of the block grant in the third and fourth grant periods the Ministry could expect the further problems of service variations due to resource deficiencies to disappear. In this context it would be reasonable to suggest that the poor view taken of the grant reduction control as a means to coerce backward or extravagant authorities by external observers was not shared by Ministry officials.

A more optimistic interpretation of local health provision and implementation of the 1929 Local Government Act, taking account of the many mitigating factors, during the 1930s is given further credence by the fact that in planning for a national health service during the Second World War Ministry of Health officials continued to think in terms of one based upon local government. Even Webster, who is more critical than most in his criticisms of local authority health services in the 1930s, recognises the continuation of basic Ministry sympathy to local authorities in the late 1930s and early 1940s, and that, but for the antagonism of the medical professions for local authorities as health providers, the latter rather than the former would have been the principal focus of attention in the 1946 National Health

Service Act. Even then Local government remained an important third part of the National Health Service from 1946.[87]

Research findings on the implementation of both the exchequer grant and poor law (health care) reforms, therefore, have found some evidence for success and, in freely discussing problems, have, nevertheless, found grounds for endorsing the reforms as essentially still rationally based, well conceived, heroically won and successful. The only principle in the 1929 reforms which was root and branch opposed in the 1930s was that of derating, which, of course, had not until the last minute been a part of reform package, and even then was forced upon Chamberlain and the Ministry of Health.[88] The problems of implementation instead were primarily caused by the effects of the recession in the 1930s and unforeseeable difficulties in implementing certain points of detail.

Moreover, historians record the many ways in which central departments and ministers kept faith with the structure of local government and the principles of grant and service reform, created in 1929, during the 1930s and over the next forty years. The local government structure essentially remained until 1972 that which was

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87 Webster, The Health Services Since the War, Volume One, Problems of Health Care:the National Health Service Before 1957, p9 and pp.16-24. See also J.Pater, The Making of the National Health Service, and F.Honigsbaum, Health, Happiness and Security (1989).

88 See, for example, Newcomer, 'English Local Government Under the Local Government Act of 1929', Political Science Quarterly, 51, 1936, p.546.

created in 1929. Foster et al, Stacey and Jackman highlight the 1929 Act as establishing the needs-based principle in central grants to local government, which has been expanded to other local services with ever-increasing sophistication ever since.[89] Local government has also remained an important focus for the direct public provision of social policy, this role only coming under threat in the 1980s. The 1929 reforms have, therefore, been firmly established as an important stage in the long-term liberal conception of the improvement of the institutions of government to meet the problems of modernity. Making comparison, perhaps, with the approach to local government reform in the 1980s, Dilks characterises the overall approach to reform in 1929 as one which with profit could have been replicated ever since.[90]

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This discussion of historians' conclusions on the 1929 reforms, has been based upon a selective but, nevertheless faithful, analysis of the works cited. The concepts used to characterise their findings-rationality, neutrality, uncontroversial policy development, liberal reformism, pluralism- are not to be found explicitly stated but, nevertheless, commonly are used implicitly in the linear description of the formulation and

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89 C.D.Foster, R.Jackman and M.Perlman, Local Government Finance in a Unitary State (1980), p.184; Stacey, thesis, pp.318-320; R.Jackman, 'Local Government Finance' in Loughlin, Gelfand, and Young ed, Half a Century of Municipal Decline, pp.161-166.
90 Dilks, Neville Chamberlain, Volume One:Pioneering and Reform 1869-1929, p.577.

implementation of the reforms. The present thesis aims to critically discuss this conceptualisation of a received orthodoxy and the empirical findings upon which it is based. In so doing it largely avoids detailed reconsideration of the inter- departmental relations and high politics of reform. The obstacles placed in the way of the Ministry of Health's reforms by the Treasury and the machinations of Cabinet politics throughout the 1920s are not in dispute. Instead it focuses on providing a discussion of the policy formulation and implementation of the reforms themselves in what may be termed the policy arena of local government reform.

CHAPTER TWO

THE ORIGINS OF REFORM

This chapter seeks, first, to reconsider the assumption of the rationality of the 1929 reforms by looking at other contemporary and historical writings. Secondly, through a brief review of theories of the state and local government reform, it will reconsider the hypothesis that government behaves neutrally in the development of reform. From these bases a theoretical perspective on the context of the formulation and implementation of the reforms will be advanced. Finally, the chapter will reconsider the historiographical and empirical evidence on the origins of reform in the years immediately after the War in the light of such a perspective. This last section will also add to and revise existing empirical understanding of the origins of the poor law (health care) and exchequer grant reforms in the Ministry of Health.

1. POLICY CHOICE AND THE RATIONALITY OF REFORM

Against the sympathetic approach to the 1929 reforms summarised in the previous chapter there exists an alternative literature which is more hostile. This draws its original inspiration from critiques offered by the Webbs, but in fact goes much wider than their concentration on the poor law reform. This literature reveals the inappropriateness or inadequacy of the 1929

reforms to solve perceived problems of local government, central-local relations and public policy making; how such problems were exacerbated and expanded by the impact of the First World War, and by the impact of the slump in the 1920s; and the extent to which alternative policy options for their solution were aired before and after the First World War. These criticisms of the 1929 reforms, together with the alternative policy options and their justification, need to be discussed in order to establish that the apparent policy consensus after the War for poor law (health care) and block grant reform was merely one element in a wider intellectual debate on the route which reform should take.

(i) CENTRAL-LOCAL RELATIONS

Proponents of the block grant reform in 1929 stressed its aim to free local authorities from detailed central control over individual items of grant-aided expenditure. Many contemporary observers cast doubt over this being the most appropriate means of defending local democracy against central control. The problem of centralisation had, according to Robson, expanded since the mid-19th century and took many forms.[1] Moreover, central government's willingness to use its armoury of controls increased during the 1920s and 1930s. Robson highlighted

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1 W.A.Robson, 'The Central Domination of Local Government', Political Quarterly, vol iv, no 1, Jan-March 1933, pp.85-104.

the surcharging of the Poplar borough councillors by the district auditor in 1925 as a prime example of central government overturning local democratic choice.[2] The more worrying long-term trend was the extent to which local authorities had come to rely on central funding, a reliance which gave central government its main basis for control. In the early 19th century local government had derived its funding almost wholly from local sources of revenue. Dependency on central grants grew from the mid-19th century with the growth in responsibilities, a trend which was accelerated during the period of the First World War and immediately after. By 1920 30% of local revenue expenditure (compared with the pre-war figure) was derived from exchequer support.[3]

The block grant promised to reduce detailed control over items of grant-aided expenditure, but its partial nature meant that 2/3 of exchequer support was still based on specific grants with detailed control. Moreover, the Local Government Act, in including the derating of agriculture and 3/4 derating of industry and the railways, reduced the local basis for raising income, and in giving compensation through the block grant increased local reliance on central funds. By 1939 40% of local expenditure was exchequer funded. Whilst the utility of the section 104 control over block grant

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2 W.A.Robson, The District Auditor, "An Old Menace In A New Guise" (Fabian Tract, 214, 1925). See also Milton E.Loomis, 'Some Random Comments on British Local Government', Public Administration, 1939, pp.365-372.

3 See A.T.Peacock and J.Wiseman, The Growth of Public Expenditure in the United Kingdom (1961), p.200.

spending for central government may be debated, it was certainly perceived by some contemporaries as being potentially even more coercive than percentage grant controls. In the long-term he who paid the piper would inevitably call the tune. Crowther concludes that the 1929 Act "was one of the most important pieces of legislation in the twentieth century, beginning a long process of centralisation".[4] Hence, contemporary observers and historians have often seen the 1929 block grant as centralist rather than a measure to enhance local democracy. To genuinely reverse the trend towards the erosion of local democracy a rather different measure was needed.

Contemporaries within government spending departments also cast doubt on the appropriateness of a block grant reform to control the level of exchequer support to local authorities. If it was simply a measure to be able to confidently budget grant aid expenditure at the beginning of a year that central government was after then a simple technical revision of specific percentage grants could have been developed. However, to spending departments other than the Ministry of Health it appeared that the Treasury campaign for a block grant to be set for periods of years in this respect represented a more general desire to limit the growth of central-aid in respect of the expansion of local services, thereby throwing responsibility back on to local authorities to make

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4 M.A.Crowther, British Social Policy, 1914-1939 (1988), p.77.

efficiency savings to continue expansion. This, it was believed would have an adverse effect on local services. For local authorities were making expenditure only on that which they were required to by legislation, and the central departments responsible for grant relations found little evidence during the 1920s for censuring individual local authorities for extravagance. Indeed, it was hard for central officials to imagine any greater incentive than the financial crisis produced in many local authorities by the slump for improving efficiency. In this context the block grant, rather than a tool to merely shift some of the responsibility for service expansion back on to the localities, appeared to erode the very fiscal basis necessary for successful local delivery of legislated services. If exchequer support were to be limited without having this effect then an alternative policy reform was needed.

The most commonly advocated solution to both the problems of the erosion of local democracy by the growth of grants and the central control of grant aid was the development of new sources of local income. They would both thoroughly revive the fiscal basis for local democracy and reverse the seemingly uncontrollable growth in exchequer support as local spending annually grew. Many suggestions for a local income tax or the rating of site values had been made before the First World War, and the argument grew stronger in the 1920s as the financial position of many local authorities grew worse. Again in the 1930s the AMC pressed the Ministry of Health for a

royal commission on land taxation, and in 1939 London County Council unsuccessfully tried to promote a bill for the rating of site values.[5]

The block grant was also found wanting with regard to the aim of equalising local authority resources. Bowen, writing in 1939, commented on its weak equalising tendency during the first two block grant periods and declared that "the popular view is entirely unfounded that the Local Government Act of 1929 will, when it is brought fully into operation, result in a distribution of grants conditioned largely upon factors relating to need and ability. The Act has made a beginning, but only a very small one."[6] Sykes, writing in the same year, came to the same conclusions, commenting upon the inability of the block grant formula to reflect need consistently.[7]

Their criticisms came in the context of lengthy advocacy of alternative solutions to the problem of resource equalisation which precluded the move towards a block grant. First, the vast majority of evidence to the Meston Committee had revealed the view that many still felt that percentage grants were necessary to stimulate local service development. Standards had not reached such a stage that initial stimulation should be abandoned

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5 G.Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance (cmd. 6453), PP (1976), p.106. See also editions of the Municipal Review and County Councils Gazette 1920-1921 for regular claims that the growth of local services was exhausting local resources and new sources of local income were required.

6 H.R.Bowen, English Grants-In-Aid, A Study in the Finance of Local Government (1939), p.106.

7 J.Sykes, A Study in English Local Authority Finance (1939), p.126.

altogether for equalisation and it was feared, in spite of arguments against, that grant needed to remain specific for infant services, such as maternity and child welfare, or grant would be mainly spent on already developed services. Committee evidence and some of the committee's members, therefore, proposed only the revision of percentage grants so as to make them related to need as well as local spending. The most commonly aired means of doing this was to create a standard unit of cost of services aided against which the cost for each local authority could be compared. Grant distribution could be made at least partly on this basis.[8] Those who, nevertheless, advocated the complete shift to a block grant insisted that it would only have the desired equalising effect if it was distributed on the basis of a formula based upon uniform rateable value, which would provide a consistent index to need.[9]

As well as these revisionist grant reform alternatives to the block grant reform which was enacted, there were more far-reaching ideas which involved an attack on the inequalities between local authority resources at root. These involved the reform of local rating areas. For instance, as early as 1912, Lloyd George outlined to Sir John Kempe the option of enlarging rating areas so as to include both poor and wealthy rating areas. This would

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8 M.Schulz, 'The Development of the Grant System' in C.H.Wilson ed, Essays on Local Government (1948), pp.128-131.

9 See, for instance, Sykes, A Study in English Local Authority Finance (1939), pp.233-291 and D.N.Chester, Central and Local Government: Financial and Administrative Relations (1951), pp.256-280.

inevitably mean the enlargement and reduction in the number of local authorities. Alternatively, local authority areas could be unified for certain services, whilst retaining autonomy over others. A final idea was that rating areas could maintain total autonomy, but that wealthy authorities be compelled to contribute from their rate income to the resources of poorer authorities.[10] If any of these options had been combined with the development of new sources of local income to further erode reliance on central funds then an inter-war local government reform could have involved quite a radical restructuring of local government and central-local relations, which could have, as some noted at the time and in the 1930s and 1940s, solved the problems of local democracy, fiscal autonomy and area inequalities rather more permanently than the 1929 reforms.

(ii) LOCAL GOVERNMENT STRUCTURE AND SERVICES

Debate about the root problem of inequalities between local authority resources and its solution by means of reform of rating areas was part of a larger debate about local authority areas. Arguments for the concentration of the structure of local government in the counties and county boroughs rested upon them being the largest local authority areas, in which the co-ordination of services and the economies of scale in service provision could be

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10 ibid, pp.125-126. See also Bowen, English Grants-In-Aid, A Study of the Finance of Local Government (1939), pp.132-141.

most properly attained. However, others perceived that the rate of social and economic change, involving the development of transportation and the movement of population, rendered even these areas as obsolete in the attainment of these aims. County boroughs may have attained their status by virtue of having populations of over 50,000, but by the 1920s variations in population growth had sent some over 1,000,000 and left others stagnating. Consequently, county boroughs varied enormously in terms of population and rateable value and their potential to realise a similar standard of service co-ordination and economies of scale was highly questionable. A similar situation existed with regard to the counties.[11] A system of central income redistribution appeared comparable to placing a plaster over a gaping wound.

Such area problems were compounded by rigidities in the reform of areas. By the 1920s many county boroughs had expanded their populations in to county areas. Whilst many had already achieved an expansion of their boundaries many more were queuing up. At the same time there were many urban second tier county authorities which had reached the 50,000 population threshold and sought county borough status. Both developments threatened county councils with loss of land, population and rateable value, which they duly resisted. The dispute between town and county was deliberated by the

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11 V.D.Lipman, 'Development and Boundary Changes (1888-1939)' in Wilson ed, Essays on Local Government, pp.25-42.

Royal Commission on Local Government, and their conclusions resulted in an act of 1926 which essentially called a halt to new county borough creations.[12] The defence of the county was, therefore, made at the expense of the perpetuation of a system of local government areas, which did not logically relate to population or capacity for functional responsibility.

This had unfortunate results for the co-ordination of services. For example, as Abel Smith shows, in both Leicestershire and Nottinghamshire, separate sanatoria for infectious diseases were erected by county borough and county council only five miles from one another. This was caused by there being population concentrations on either side of the county borough boundary but no one authority to provide one sanatorium for the whole catchment area.[13] The encouragement of more joint action between local authorities was an option for central government to overcome such problems, but local authorities commonly avoided joint boards and committees because of the competition that existed between them and the fear that joint action was tantamount to suggesting that they were not in themselves viable local authority areas.

Such problems in the existing structure of local government led many contemporary analysts to suggest the creation of a completely new structure based on larger areas, which embraced poor and wealthy areas, were

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12 ibid, pp.42-45.
13 B.Abel-Smith, The Hospitals, 1800-1948 (1964), pp.371-372.

comparable in terms of population and rateable value, and, consequently, could achieve the kind of functional efficiency that local government reformers in the 1920s were seeking. This alternative policy option for solving the structural problems of local government was expressed in terms of the call for regionalism and came most strongly in the period immediately after the First World War from such academics as G.D.H.Cole and C.B.Fawcett. Further, the argument for regionalism as a general reform of the local government structure was increasingly applied to individual service needs, including hospital provision.[14]

The wider debate about relating local authority areas to functional efficiency coincided with other debates concerning the problems of and solutions to individual social policies. The first concerned the actual content of policy. Despite its apparent inspiration from the 1909 minority report, the 1929 poor law reform was denounced by the Webbs for not going far enough to meet the aims of that report. In public assistance, the administrative Problems of registration, charge and recovery were not confronted: the divisiveness of pauper status was retained; and local authorities were given comparatively little guidance on how to conduct public assistance. More importantly, a contradiction was left in the continuation of deterrent public assistance side-by-side with progressive public health services, and the

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14 See B.C.Smith, Regionalism in England 2:its nature and purpose, 1905-1965 (Acton Society Trust, 1965).

provision of enabling powers only for local authorities with regard to the reorganisation of transferred poor law services. In short, the reform failed to break up the poor law, and in so failing, discouraged the desired unification of local health services. To the Webbs a thorough separation of local health services from public assistance was essential and the only way of achieving the aims of the 1929 reforms with regard to local health care. More recently, Gilbert has agreed with this analysis, suggesting that apart from the partial stimulus given to the growth of municipal hospitals the reform of the poor law "did not nearly accomplish the unification of institutional health facilities that had been the ideal of all Ministry of Health advocates."[15]

The second debate, of course, related to responsibility for social policies. Whilst there was a wide consensus at the end of the First World War over the maintenance of the poor at some level of local government, the experience of the 1920s revived the argument of the pre-war advocates of national responsibility for the unemployed.[16] The assumption underpinning the transfer of the poor law to larger local authorities was that the poor were a local responsibility. However, the growth and persistence of unemployment during the 1920s, which threw huge numbers

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15 S. and B.Webb, English Poor Law History, Part II, Volume II (1929), pp.990-1023 and B.B.Gilbert, British Social Policy, 1914-1939 (1970), p.235.

16 See J.Harris, Unemployment and Politics, A Study in English Social Policy, 1886-1914 (1972), chapters 4 and 5.

on to the poor law, was perceived as being caused by national factors. National government should, therefore, pick up the responsibility for what was a national problem. Even as the 1929 Local Government Act passed on to the statute books there were many, including the Webbs, who called for the integration of out-relief in to national schemes of unemployment assistance.[17] This would have ensured a more integrated approach to the relief of the unemployed than that which pertained in the early 1930s when there was still a multiplicity of national and local relief agencies dealing essentially with the same problem. Such arguments were validated by the 1934 Unemployment Act. The nationalisation of unemployment relief would also have automatically separated public assistance from health care and allowed the better unification of local health care.

There were also contemporary experts who perceived the problems of health care organisation in a wider sense and advocated quite radically different solutions to that pursued by the Ministry of Health and Neville Chamberlain, or indeed the Webbs. Notable amongst these was Lord Dawson, who was appointed as the first Chairman of the Ministry of Health Consultative Council on Medical and Allied Services. The Council's interim report, published in 1920, reflected much of what Dawson had argued during the War, when involved in the organisation

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17 See, for example, The Economist, 26.1.1929, pp.147-148. See also N. and J.MacKenzie (ed), The Diary of Beatrice Webb, Volume Four, 1924-1943, The Wheel of Life (1985), p156.

of war-time medical care.[18] Where the Maclean Report only considered local public health services, Dawson thought in terms of the problems of co-ordination between them and other health care agencies, notably general practitioners under the national health insurance scheme and voluntary hospitals. If a state medical service was developed only on the basis of local authority services then serious overlaps, wastage and deficiencies could develop between the different health care agencies.

The positions of general practitioners and voluntary hospitals could also by themselves become problematical. In 1920 many voluntary hospitals were already experiencing considerable financial problems, and the general practitioner faced similar hardships if his/her clientele were limited to insurance patients in a period when income form private patients dropped. Dawson considered that it would be potentially disastrous for the quality of health care if it was developed on the basis of less well qualified local authority medical officers than the highly qualified general practitioners and hospital consultants.

The Dawson Report offered as a solution to these larger problems the concept of a universal system of health centres, in which fully co-ordinated provision could be made for all. The health centres would be the primary means of health care, staffed by general

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18 The Consultative Council on Medical and Allied Services, Interim Report on the Future Provision of Medical and Allied Services (Dawson Report) (cmd.693), PP (1920).

practitioners, from which patients could then be referred to hospital or other forms of care. Implicitly, Dawson was advocating a national health service, with all forms of health care being brought within one co-ordinated system. Dawson was not a lone voice. The Labour Party Public Health Advisory Committee was thinking along the same lines, and the county medical officer of health for Gloucestershire prepared a plan after the First World War for how such principles could be applied at a local level. Such ideas pre-dated the practical application of universal co-ordination in the National Health Service Act of 1946 by over twenty years. It may also be pointed out that side-by-side with the Dawson Report there were also more limited advocacies for an extension of the 1911 national health scheme, although this was not explicitly assumed by the Dawson Report.[19]

There were, therefore, broader options for the reform of local government and for the reform of the social policies, with which the Ministry of Health and Neville Chamberlain were concerned, in existence in the period immediately after the First World War. Whilst the 1929 Act has invariably been portrayed as a comprehensive reform of the structure, organisation, functions and finance of local government, the substance of these

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19 See C.Webster, The Health Services Since the War, Volume One, Problems of Health Care:the National Health Service Before 1957 (1988), chapter two. See also F.Honigsbaum, 'Unity in British Public Health Administration:the failure of reform, 1926-1929', Medical History, 12, 1968, pp.109-121. Honigsbaum discusses how and why attempts to unify local authority and general practitioner services failed during the 1920s.

alternative proposals and the arguments for them suggested the limited nature of the poor law and exchequer grant reforms pursued during the 1920s for the solution of perceived problems of local government, central-local relations and public policy. One may doubt the weight to be attached to these alternative policy options. Advocates of new sources of local revenue, for instance, advanced few practical plans, and generally spoke without concern for the complex administrative reforms which would also be necessary. Proponents of regionalism, as Owen has shown, did not share a coherent voice. There were considerable differences over what constituted a region and even over whether regional government should completely replace existing local government, or simply be added as a new tier.[20] Similarly, the Dawson Report willfully omitted to prescribe a clear role for the local authorities or the voluntary hospitals in its advocacy of co-ordinated provision, and made no mention of how a reformed system would be funded. Further, for all of these policy options, immediate opponents from the vested interests affected could easily be imagined.

Yet, it is clear that for government policy on reform to have been rationally conceived such alternative policy options should have been more systematically considered within government. Lindblom specifically suggests in his

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20 See J.R.Owen, 'Defending the County? The Reorganisation of Local Government in England and Wales, 1935-1950' (unpublished PhD.thesis, Bristol University, 1990).

conceptualisation of the rational-comprehensive (root) method of policy development that in order to conduct rational policy making government must clarify objectives and make comprehensive analysis of all of the policy options available for their achievement.[21] This the Ministry of Health did not do after the First World War. If officials considered alternative options at all they were quickly dropped. The question that should then be posited is why not. Why and how was a course set fair for the 1929 reforms at the end of the First World War which precluded debate of alternative policy options, some, in the case of the Dawson Report, developed within government itself?

2. TOWARDS A THEORETICAL PERSPECTIVE

The views on local government reform in the inter-war period discussed above have considerable value in revealing that choices, whether, explicitly or implicitly, were made in the formulation of reform. Dearlove, however, roundly condemns the analysts of missed opportunity for still being based in orthodox assumptions of the democratic and technocratic nature of the modern state and of the consequent imperatives in central government in the reform of local government.[22]

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21 See C.E.Lindblom, 'The Science of Muddling Through', Public Administration Review, vol 19, no 2 (1959) reprinted in D.S.Pugh ed, Organisation Theory, Selected Readings (1971), pp.238-255.

22 See, for example, L.J.Sharpe, 'Theories and values of local government', Political Studies (1970), vol 18, no 2, pp.153-174.

In arguing for alternatives to local government reform such analysts, according to Dearlove, merely propounded different methods for good government in a democratic society, and, thus, assumed that central government was only guilty of making the wrong choices in reform. The persistence of the advocacies for a local income tax, or regionalism, or greater local democracy in the late twentieth century is evidence of the continued faith placed by analysts in the democratic process to improve government. Dearlove suggests at a general level that the high level of involvement of such analysts in the reform debate denies them the necessary detachment to analyse the underlying and detailed reasons why, in fact, the choices that were made in local government reform in the inter-war period, as for any other period, were made as they were.[23]

Such detachment, according to Dearlove, involves a quest for an alternative rationality in the making of local government reform to that of solving the problems of local government, central-local relations and public policy in a democratic society; a rationality based instead in the sectional interests that government policy represents, and the way in which local government reform may serve those interests. To be fair to the historians Dearlove's sweeping condemnation omits recognition of the interpretive content of their work which has supplied certain answers to how and why the 1929 reforms were

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23 J.Dearlove, The Reorganisation of Local Government (1979), pp.1-19.

originated and achieved, and it is to their perception of the rationality lying behind the reforms that one must first turn.

The Webbs suggested that the attack on the poor law was part of a general attack on the Labour Party by the Conservative administration under Stanley Baldwin. This was rooted in fears of the spread of the Russian Revolution in the early 1920s, the prospects raised by the general strike in 1926 and the way in which various boards of guardians had illegally helped strikers. Local government was reformed, therefore, to reduce Labour strength in local government and remove responsibility for the poor law to more politically 'reliable' local authorities.[24]

Gilbert finds such an interpretation too crude, and instead characterises Neville Chamberlain as a rationaliser, bureaucratic in temperament and more concerned with how things should be done than what should be done. Hence, Chamberlain reformed the poor law out of a desire to see administrative order where chaos was prevalent. He was concerned with the organisation of services rather than their content. Explicitly this suggests a non-political approach to reform. Implicitly, however, the values that defined Chamberlain's bureaucratic temperament were political in that they found alternative approaches to poor law administration

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24 S. and B.Webb, English Poor Law History, Part II, Volume II (1929), pp910-912. See also B.B. Gilbert, British Social Policy, 1914-1939 (1970), p.219.

taken by the Labour party to be a source of chaos.[25] Crowther took this line of argument further by suggesting that Chamberlain's pursuit of poor law reform in the late 1920s was implicitly the politically motivated preservation of a system of social policy which serves the interests of one class over another.[26] Branson, a supporter of poplarism, identified the favoured class as composed of employers and ratepayers.[27] The concentration on values that constrain political decisions is more subtle than the focus of the Webbs but is essentially sympathetic to their line of interpretation. Coherent if varied critical interpretations of the rationality employed in the origins of the 1929 reforms, therefore, exist.

There are, however, a number of problems in this literature. First, there are errors or important omissions of fact in the analyses of Gilbert and Branson. Gilbert judges that the Labour government of 1924 "scarcely considered" a reform of the poor law. One may judge that their consideration was not important but not that it did not happen. More importantly, in his description of the composition of the block grant Gilbert refers only to compensation for derating and the additional amount. The important issue of compensation

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25 Gilbert, British Social Policy, 1914-1939 (1970), pp.219-235.
26 M.A.Crowther, The Workhouse System 1834-1929 (1981), pp.102-103.
27 N.Branson, Poplarism 1919-1925, George Lansbury and the Councillors Revolt (1979), p.223. see also P.A.Ryan, 'Poplarism' in P.Thane (ed), The Origins of British Social Policy (1978), pp.56-83.

for discontinued grants is omitted.[28] Branson finds Chamberlain to be the principal author of not only poor law and exchequer grant reform but also derating. A reading of any other analysis would show that Winston Churchill instead had claim to this dubious privilege.[29]

Secondly, the scope of interpretation is limited. All the analyses cited refer primarily to the origins of the poor law reform and devote little attention to exchequer grant reform. Further, the origins of poor law reform are discussed primarily in terms of the crisis in unemployment relief during the 1920s, rather than in terms of debates about local government structure or health care. Other writers, such as Bowen, Sykes and Chester, who are otherwise critical of the exchequer grant reform, make no effort to consider why such a reform was passed.

Thirdly, in its focus on Neville Chamberlain as the principal 'actor' the literature lacks scope in its discussion of the origins of the reforms. In particular, there is no comprehensive critical re-examiniation of the role of the Ministry of Health or of interests involved in reform, notably the various local authority associations. One should be mindful that the Webbs were writing so close to events that the expectation of such examiniation is unreasonable, and that the principal focus of Crowther's work was different from that of this

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28 Gilbert, British Social Policy, 1914-1939 (1970), p.211 and 230.
29 Branson, Poplarism 1919-1925, George Lansbury and the Councillors Revolt (1979), p.223.

thesis. However, the limited range of interpretation and the lack of comprehensive consideration of the different origins of the reforms do serve to reflect how Gilbert's analysis remains an inadequate critical response to the favourable orthodoxy on the origins of the 1929 Act.

Consequently, it may be judged that whilst the critical orthodoxy on the origins of the 1929 reforms provides some stimulus to the debate, it is currently flawed as an attempt to provide a cogent explanation of the rationality which lay behind the reforms. Either problems of fact abound, the focus of interpretation is too narrow or issues remain under-researched. These flaws need to be corrected. It is important, however, to clarify a plausoble theoretical basis to a critical empirical re-examination of the origins of the 1929 reforms. Here also one needs to go beyond the work of the Webbs et al, and consider what responses have been made by other analysts to Dearlove's call for a quest for an alternative rationality in the making of local government reform.

A number of quests have been made based on marxist assumptions, which address the rationale for area, service, and financial reform. First, Dearlove, himself, suggests that the state is dominated by the ascendant capitalist class, and that far from being institutions of democracy, local authorities are foci of power within the state for the control of the capitalist class at a local level. His broad thesis is that local government reform has been directed towards the concentration of local

government in areas, in which the control of the capitalist class can be best sustained.[30]

O'Connor addresses the question of local government reform in terms of service provision. He argues that the organisation of the state is determined by the need within the state to segregate itself according to the two different types of state expenditure made. The first is social capital, which is expenditure intended to help in the private accumulation of profit. Social capital is further sub-divided in to social investment, which improves labour productivity, and social consumption, which reduces the cost of reproducing labour. The second type of expenditure is social expenses, which is expenditure made primarily to maintain social order/harmony. O'Connor suggests that the state is segregated so that services with a primary function of social capital are within the orbit of the central state and those with a primary function of social expenses are the responsibility of the local state, and that local government is reformed so as to ensure this balance. This is the essence of what has been termed the dual state thesis. O'Connor recognises, however, that local services with a primary function of social expenses may also have functions as social capital. For instance, it could be argued that expenditure on education increases labour productivity and that on education, housing and recreation reduce the costs of reproducing labour.

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30 Dearlove, The Reorganisation of Local Government, part one.

However, their primary function in the interests of capitalism is to maintain social order/harmony.[31]

The question of financial reform has been addressed by Martlew. He is less concerned with why and how functions are segregated in the state. Instead he argues that attempts to discern different types of state expenditure are futile in the face of evidence that all expenditures can be perceived as being simultaneously social capital and social expenses. Instead he assumes a position in which local government takes responsibility for key expenditures, and argues instead that financial reform is determined by a conflict between the desire to promote state spending "in general" and the need to control state spending "in general". The former may contribute to the interests of capitalism in terms of reproducing labour or providing social compensation that assists in the maintenance of social order. The latter may also contribute to the interests of capitalism by minimising fiscal burdens on the productive sectors of the economy, thereby maximising the savings available for capitalist investment.

Martlew observes that the conflict within the state is played out between the Treasury on the one hand, with certain support in local government and elsewhere, and the spending departments on the other, again with certain support from elsewhere in the state. The former aspires to control public spending "in general" whilst the latter are a major determinant of the rise in public spending

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31 J.O'Connor, The Fiscal Crisis of the State (1973).

"in general". This conflict over spending policy is seen as a continuous and never-ending process, and one which reaches crisis when during a depression in the economy both demands of capitalism are at their most intense: capitalists are in need of low public expenditure in order to provide the potential for new investment; and for the sake of social order higher public expenditure is required. Martlew's general thesis is that it is the outcomes of such public expenditure controversies which determine the reform of local government finance.

The added value of Martlew's work is that it is applied to the historically specific circumstances of exchequer grant reform in the inter-war period. In his interpretation, the Treasury in the 1920s exhibited none of the liberal concerns for local government or for the creation of a finance system which allowed the poorest authorities to meet social need where it was at its very highest. Instead the sole interest was the reduction of government expenditure so as to minimise the burden of taxation on the process of capitalist accumulation. "A block grant would limit the exchequer's liability and place the burden of financing higher spending on the relatively less buoyant rates." However, this presented the knock-on problem of making it necessary for local authorities to raise their rate demands, which would again increase the economic costs faced by producers. Hence, agricultural and industrial derating were introduced by the Treasury so that the process of

capitalist accumulation could not be hampered from any part of the state.

Against this stood the forces in the central and local state which favoured expenditure increases. There was continued support for percentage grants. However, there was also the move towards equalisation of local authority resources. This came chiefly from the Ministry of Health but also had other supporters which Martlew does not elaborate upon. It was in the first place linked to the capitalist-inspired aim of maintaining social order in a society of increasing expectations. Martlew points out "as services became well established minimum standards increased and attention increasingly turned to more uniform provision." Martlew claims that the need to bring about equalisation was also linked to three other key reasons. First, continuing uneven service provision might lead to economic distortions in the market mechanism. Secondly, the equal provision of services was increasingly coming to be seen as a right necessary for the legitimacy of the system. Finally, and most importantly, local government in some parts of the country would simply have broken down; unable to meet local economic and social needs and unable to finance the ever increasing service obligations imposed by the centre. Hence, the thinking in favour of equalisation of funding through the employment of a needs based formula for the block grant was economic and political as well as

social. This aspect of the block grant reform therefore satisfied the needs of capitalism in several ways.[32]

Despite the attractiveness of this and Dearlove's and O'Connor's conceptualisations of reform, they do, however, have considerable problems in explaining why the Ministry of Health formulated reform on the basis that it did after the War. Dearlove's thesis suggests a valid explanation of central government's preference for the concentration of local government in the counties and county boroughs, which were areas of identified community of economic interest, and which were often also areas large enough for a concentration of working class population to be counteracted by the presence and domination of middle class populations. This was in contrast to boards of guardians areas, for instance, which, as the phenomenon of poplarism had shown in the 1920s, could be captured by the working class; the poor law then being administered in the poor's own interests. However, it does not explain why, as a result of socio-economic change and the concentration of unemployment in certain county boroughs and county areas by the inter-war period, government did not perceive a need to reorganise local government in to even larger areas, such as regions, to preserve capitalist control.

Similarly, O'Connor's work provides a new means of understanding why central government in the 1920s should consider the reform of the poor law and health care, both

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32 C.Martlew, 'The State and Local Government Finance', Public Administration, 61 (1983), pp.127-147.

arguably social expenses, only in terms of provision by local government. However, the problem with O'Connor's work is that it is formulated with reference to the U.S.A. and is barely applicable to the British local government experience. It cannot explain why unemployment relief and health care were nationalised so soon after the 1929 Act. Similarly, it would be difficult to argue that roads and planning, consistently major responsibilities of local government, were social expenses, whose principal objective was to maintain social order amongst the working classes.

Finally, Martlew's analysis is valuable for providing a wider context for characterising the institutional interests within the state which determined the need for reform, and why reform should be delayed whilst the different interests came to agreement which was mutually acceptable. The problem with Martlew's analysis, however, is that its empirical content is almost entirely derived from the work of Rhodes and replicates the linear description of the development of policy. Martlew does not, therefore, explain why the block grant was promoted when other policy alternatives existed which could have achieved the control of public expenditure "in general" and promoted the equalisation of public expenditure through local government, as well as maintaining the legitimacy of local government.

Despite the problems of these marxist models of local government reform their assumptions concerning the class interest rationality of government policy making present

a fundamental challenge to the rational, neutral bureaucracy and pluralist polity assumptions present in the received orthodoxy. Marxist assumptions are not endorsed by the majority of historical and contemporary policy analysts, yet the challenge posed by marxist analysis has forced them in to the recognition that an explicitly theoretical perspective on the role of government in society, and the interests which determine its behaviour, needs to be taken in order to provide a context for understanding why and how government adopts certain policy options rather than others. It has also provoked them towards reappraisal of the conceptual assumptions which implicitly inform the received orthodoxy.

Intellectual responses have essentially focused on the revision of the assumptions which inform the received orthodoxy. Recognition is made of the complex and extensive role played by government in the lives of citizens in the twentieth century and that as a result the focus of policy making is narrowed down to fewer actors, who may be deemed to form an elite. The composition of the elite and the interaction of the interests embraced within it determine the rationality of policy making. Analysis of the post Second World War period generally assumes an elite policy making process composed of the interaction of government, composed of

politicians and bureaucrats, and interest groups, who represent wider interests in society.[33]

One thesis suggests the development of a corporate state, where the representatives of capital and labour are singled out and incorporated as extra-governing institutions in to the central policy making process. Liberal corporatists would suggest the intentions involved to be that of government attempting to share power with key economic interests in order to produce policy which reflected wider interests. Radical corporatists would, however, suggest a conspiratorial intent on the part of government to incorporate key economic interests as a means of gaining consent for policy which essentially preserved the interests which the governing elite represented. Hence, the representatives of employers and labour are given power and prestige in return for their compliance in government formulated policy. Such representatives then control any of their members who may form a challenge to the making of government policy.[34] The relevance of this thesis has been promoted by Middlemas, who characterises the inter-war period as one of the emergence of corporate bias. This explains the emergence of industrial peace and policy consensus in the period after the 1926 general strike.[35] Middlemas does not, however, address the

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33 See, for a summary, P.Dunleavy and B.O'Leary, Theories of the State, The Politics of Liberal Democracy (1987), chapters four and six.
34 See, for further discussion, W.Grant (ed), The Political Economy of Corporatism (1985), chapter one.
35 K.Middlemas, Politics in Industrial Society (1979).

question of how this context for policy making should determine the rationale for local government reform in 1929. Saunders offers a potential application which derives heavily from O'Connor's model of the functional segregation of the state. Essentially, Saunders argues that policies which are a subsidy to capital (social investment) are kept at at a national level, where they can be determined by a corporate policy process, and policies which are a subsidy to the working population (social consumption) are kept at a local level, where they are determined by non-incorporated interests such as public service clients and small businesses. The segregation of the state in this way avoids a conflict between long-term corporate strategies and democratic accountability to more plural interests.[36]

In terms of applicability to empirical analysis, Saunders' theory shares the same appeal and weaknesses as O'Connor's model. Whilst one may seek to refine a corporatist approach to the 1929 Act there is any case serious doubts as to the relevance of Middlemas' theory of corporate bias in the inter-war period. Lowe's study of the Ministry of Labour refutes much of Middlemas' evidence in relation to key areas of industrial and employment policy.37 Further, as Moore's study has shown, there was virtually no business or labour interest in the form of local government reform in the 1920s. The simple but compelling point is that business and labour

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36 P.Saunders, Urban Politics (1979).
37 R.Lowe, Adjusting to Democracy, The Role of the Ministry of Labour in British Politics, 1916-1939 (1986).

interests did not commonly understand the intricacies of local government and central-local relations, much less what was at stake in the choice between various policy options.[38]

A more flexible context to the analysis of policy making is provided by Webb's conceptualisation of bounded pluralism, which suggests a more inter-active relationship between the plurality of interests and elite government policy makers, but one which nevertheless, leaves more power with the latter than the former. Webb suggests that actors and interests outside of government may represent general calls for policy reform but that actors and interests within government determine the exact nature of policy response in accord with their elite interests. The development of policy may then be made with further access given to interests outside government, but only those chosen by government. In this model, then, the general rationality for reform is given by general perceptions of problems in public policy raised by the electorate and interest groups but the specific rationality for reform is given by the interests of government actors, who ensure that policy options chosen do not contradict their elite assumptions.[39]

This model of policy making is applied much more successfully by inter-war public policy historians. Lowe highlights the importance of the social and economic

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38 S.Moore, 'Conservative Party Opposition to Neville Chamberlain's Social reforms, 1925-1929' (unpublished MA. thesis, Birmingham University, 1984), pp.202-209.
39 P.Hall, H.Land, R.Parker and A.Webb, Change, Choice and Conflict in Social Policy (1975), chapter 8.

aspirations released by the First World War, and the way in which the 1918 Representation of the People Act gave many more of the working classes the vote. Compared with a pre-war polity in which those in government remained dominant in policy making, the advancement of political democracy and social expectations created unprecedented power for those outside government to determine the general policy agenda of those in government. Demands for social reform were made at the end of the War and, although political apathy set in during the 1920s, the perception of social expectations amongst the masses, especially during the slump and recession, bore heavily upon government. Elected representatives had to take note of general calls for reform and directed the bureaucracy to respond.[40]

However, so long as political sophistication remained low those in government retained power of discretion over addressing general calls for reform. Hence, Gilbert and Thane and Lowe are in general agreement that, whilst government policy after the First World War was influenced significantly more by general demands from the plurality of interests for reform, actors in central government retained power over the formulation of the detail of reform. This power was used to ensure that any actual reform carried was not contrary to the assumptions of the elite within government. This is the essence of

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40 Lowe, Adjusting to Democracy, chapter one.

pluralism being bounded by the power of a governing elite.[41]

The nature of the governing elite and its aims in government policy are, of course, problematical. Crowther, concluding upon the work of many others, suggests that, with the exception of Neville Chamberlain, politicians in government during the inter- war period were "either inactive or, like Christopher Addison, not in office long enough to implement their wishes".[42] Hence, an analysis of an inter-war governing elite, which formulated the detail of policy, essentially involves one of the bureaucracy, or more accurately, one of the senior officials in the departments of state. Lowe characterises this elite culture in the inter-war period as operating within a capitalist consensus. However, the homogeneity of approach to policy grew out of shared social and educational values, and a common work experience. The values of the elite were, therefore, propounded on the basis of a network of personal and professional relationships, rather than anything as explicit as ascendant class goals. The kind of prejudices civil servants came to show, Lowe remarks, came from "the shared experience of work, fortified by life in the south-east in general and in London clubs in particular".[43]

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41 B.B.Gilbert, British Social Policy, 1914-1939 (1970); P.Thane, Foundations of the Welfare State (1982); Lowe, Adjusting to Democracy. See, for a discussion of their views, M.A.Crowther, British Social Policy, 1914-1939 (1988), pp.11-14.

42 Crowther, British Social Policy, 1914-1939, pp.18-21.

43 Lowe, Adjusting to Democracy, p.9.

Lowe's approach is complemented by Macnicol in his study of the emergence of family allowances. Macnicol rejects both the notion that the civil service was neutral and representative of the plurality of interests, and the idea that they were a tool of capitalist interests. Rather, the senior civil service was predominantly an upper middle class, public school and oxbridge-educated elite, which possessed great power and used it in ways biased to its own interests and social and cultural values. Such values included those of independence and self-help, the competitiveness of the economy and social consensus; values which were implicitly an endorsement of the capitalist consensus but not explicitly or functionally so.[44]

Despite such general conclusions upon a bureaucratic elite no historian would fail to disaggregate the aims of different departments within government. A major cleavage was formed between those civil servants in spending departments charged with formulating policy to respond to general calls for reform, which would commonly involve increases in public expenditure, and those in the Treasury. As Thane and Peden have emphasised, inter-war policies had to conform to prevailing views on the need for restraint in public expenditure so as to facilitate the competitiveness of the economy.[45] Hence, Treasury control, especially during the economy crisis immediately

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44 J.Macnicol, The Movement for Family Allowances, 1918-1945 (1980), conclusion.
45 Thane, Foundations of the Welfare State; G.C.Peden, British Economic and Social Policy: Lloyd George to Margaret Thatcher (1985).

after the First World War and during the slump of the 1920s and ensuing recession, has been seen as a major determinant of how the bureaucratic elite responded to general calls for reform. Such control took a number of forms. For example, the Treasury gained control over the staffing levels and senior appointments in other departments. It also sought to reign in the reform plans of other departments either after formulation, or before, through the finance officers who were newly appointed to all of the major spending departments, including the Ministry of Health, at the end of the First World War.

Even within departments analysts are careful to disaggregate bureaucratic imperatives. Greenwood and Wilson suggest that major cleavages commonly exist between different divisions within departments through competition over shares in the departmental budget, and between generalists and specialists.[46] The former attempt to take a wider view of a department's aims whilst the latter attempt to promote the specific aims of their task. Public policy historians acknowledge the internal dynamics of the workings of the inter-war bureaucracy and see these as the essential motor for and against change, and for and against particular types of change in policy.

Even if this conceptualisation of the basis for inter-war policy making is accepted the vexed question is returned to of how to provide an explanatory context for

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46 J.Greenwood and D.Wilson, Public Administration in Britain Today (2nd edition 1989), chapter six.

the adoption, in response to general calls for reform policies, of one option over another in the making of detailed reform policy. An answer is provided by Lindblom who suggests that government policy is formulated within the bureaucracy by means of the successive limited comparisons method. As a result of the reality of time constraints in evolving policy, objectives are not rigidly defined and so all policy options are not rigorously investigated for their probable outcomes. Instead, policy change is derived only from the limited comparison of existing policy alternatives which are themselves merely revisions of existing policy. This ensures that policy remains compatible with existing bureaucratic imperatives and that reform embraces more limited change than more radical alternatives developed outside government, which also have incalculable implications. In establishing the detail of reform, therefore, the bureaucracy makes only incremental changes from previous policy.[47]

This model of incrementalism has again been endorsed by historians as a means of explaining the style of policy making in the inter-war period. Lowe's study of the Ministry of Labour suggests that after the First World War only small adjustments were made to existing policy in response to generally perceived needs.[48] Fraser's general study of the study of welfare from the

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47 Lindblom, 'The science of muddling through', Public Administration Review, 2, vol 19 (1959), reprinted in Pugh (ed), Organisation Theory, Selected Readings (1971), pp.238-255.
48 Lowe, Adjusting to Democracy, pp.238-243.

eighteenth to the twentieth century uses incrementalism as an organising perspective.[49] Perhaps most importantly, Ashford has already suggested that local government reform in the early twentieth century was guided by an incrementalist approach; making adjustments to local government service responsibilities only when local government perceptibly failed. This reactive incrementalism characterised inter alia the nationalisation of unemployment relief in 1934.[50] Other studies of inter-war policy, such as Macnicol's, it should be noted, show how the alternative to incrementalism was complete inaction as the bureaucratic elite clung on to existing policy, justifying its success against all contrary evidence.[51]

From the above discussion a theoretical perspective on the nature of the policy making process in the inter-war period may, therefore, be drawn , which is applicable both to the formulation and implementation of the 1929 reforms, and which is distinctive from that which informs the received orthodoxy. A governing elite - a bureaucratic elite - primarily composed of senior civil servants is made the principal actor focus. The perspective suggests that, in not being neutral, the rationality of this bureaucratic elite was implicitly formed by imperatives of its own which, by definition, were anti-democratic. It also suggests that the end of

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49 D.Fraser, The Evolution of the British Welfare State (1984), pp.xxi-xxx.
50 D.E.Ashford, The Emergence of the Welfare States (1986).
51 Macnicol, The Campaign for Family Allowances.

the First World War and accompanying political, economic and social change created new conditions in which such bureaucratic rationality had to be applied to the creation of reform. In the formulation, and indeed, in the implementation of reform, there was, nevertheless, considerable potential for intra-departmental as well as inter-departmental conflict, and the likelihood of an incrementalist approach to the selection of policy options for reform. However, in an application of this perspective to the formulation of the 1929 reforms one needs to be aware that the one politician universally accepted as active in domestic social policy in the inter-war period, Neville Chamberlain, was involved. The relationship between Chamberlain and his officials, therefore, becomes a particularly important variable.

The theoretical perspective needs to be taken further if a new context for discussing policy formulation and implementation is to be fully provided. Webb's theory of bounded pluralism suggests that in the development of detailed reform actors in government will also commonly take account of actors and interests outside of government. This may be characterised as the way in which the interests of the bureaucratic elite are bargained with the plurality of interests. However, it appears more appropriate to consider the access given by government to outside interests in terms of the access of certain interests and the exclusion of others. In the management of reform consideration an extension of the preceding discussion would suggest that inter-war

bureaucratic imperatives for incremental, and therefore, limited, reform would make it rational to access only those interests which were in favour of only limited reform or against reform of any kind, and to exclude interests in favour of greater reform. The management of debate in this way would suggest the appearance of pluralism, but would, in reality, limit the bounds of debate. Further, if the interests accessed, in return for a governing role, have the facility to control potential opposition to government policy and demands for greater change then the arrangements may be perceived at an individual policy level in terms of a radical understanding of meso-corporatism.[52]

This approach to analysing the 1929 reforms gains greater credence from an appreciation of the literature on policy networks. According to Rhodes policy networks are "complex[es] of organisations connected to each other by resource dependencies and distinguished from other ...complexes by breaks in the structure of resource dependencies". They involve the inter- action of bodies in an agreed policy area at a sub-central government level, therefore placing reform debate well beyond the orbit of democratic institutions such as Parliament and so limiting the access of interests to policy making. Included in Rhodes' typology of networks is the inter-governmental network, in which policy debate affecting

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52 See G.Jordan, 'Pluralistic corporatisms and corporate pluralism', Scandanavian Political Studies, 3, vol 7 (1984), pp.137-153; and G.Jordan, 'The pluralism of pluralism:an anti- theory?', Political Studies, xxxviii (1990), pp.286-301.

local government is limited to interaction between government and the representatives of local government, the local authority associations. The representation of individual local authorities, service interests and public sector unions as well as all non-local government actors and interests are explicitly excluded.[53]

The concept of the policy network suggests two important points. First, resource inter-dependency is a compelling reason for accessing those interests from which compliance is essential for the implementation of policy. The scope of local government operations by the 1920s in relation to both public expenditure and service provision was such that the inter-dependency of central and local government appears a self-evident truth. Secondly, the concept suggests how the interests given access to reform consideration may be limited to the associations representing local government. National local authority associations, like other institutions, had and have the potential to control the aims of some of its members in return for a role in the governing process. This extension of the theoretical perspective is again distinctive from that which informs the received orthodoxy. It suggests that the formulation and implementation of the 1929 reforms should also be seen in terms of the management of the bounds of wider consideration to ensure that the extent of reform was not formally or successfully challenged, rather than in terms

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53 R.A.W.Rhodes, Beyond Westminster and Whitehall (1988), p.77.

of the concept of pluralism. It also suggests rationale upon which that management may have been conducted, and upon which interests outside the bureaucratic elite were served by the 1929 reforms can be understood.

Individual aspects of this theoretical perspective will be returned to and used as a basis for reconsideration of the formulation and implementation of the 1929 reforms. In the first instance, however, the concern is to relocate the origins of the 1929 reforms after the First World War, not as part of a continuum in policy debate stretching back to the official reports in which the ideas contained therein were first suggested, but in the specific circumstances of the post-war situation. Inquiry in to the origins of the poor law (health care) and exchequer grant reforms in the context of the concepts of bounded pluralism and incrementalism yields both additions to knowledge and a basis for re-interpreting the move towards reform immediately after the War.

3. THE ORIGINS OF REFORM, 1918-1920

That there was little initiative in the pre-First World War department generally responsible for local government for reform of local government structure, the finance of local government and local social provision has already been shown by other historians. The Local Government Board has generally been characterised as being plagued by inertia, weak in relations with other government

departments and represented in Cabinet by ministers of limited ability.[54] Furthermore, it is clear that none of the potential reforms discussed above were seriously addressed. Even consideration of poor law or local health services reform was dropped in the wake of the division of opinion on the Royal Commission on the Poor Law. The 1914 Finance bill, based upon the Kempe Report, had provided for health services to be provided on a block grant basis. Yet, the bill had failed to make Parliament and during the War new local health services were provided for on a percentage grant basis. Existing policy was preserved. The changes wrought by the First World War, therefore, had a vital part to play in bringing about change in central policy.

The popular expectations of social reform, released by the First World War, led the wartime coalition to set up a committee on reconstruction, which in 1917 became a ministry, under Dr Christopher Addison.[55] In the search for rapid reform proposals the sub-committee on local government, chaired by Sir Donald Maclean, was given the brief of formulating proposals for a reform of the poor law. The decision to set up the committee with such a limited brief was made on the basis of poor law reform being the only option which had been seriously considered before the War and could be developed as practical

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54 R.M.Macleod, Treasury Control and Social Administration, 1871-1905 (1968); F.Honigsbaum, The Struggle for the Ministry of Health (1970).

55 Background to the creation of this committee is provided by K. and J.Morgan, Portrait of a Progressive, the Political Career of Christopher, Viscount Addison (1980).

policy. A wider brief may have created lengthy deliberations which might not have produced any agreed policy. Hence, more elaborate consideration of the reform of local government or its services was prevented. The reform that was envisaged was one based on existing institutions of local government and without wider reference to other relief or health care agencies. The abolition of the boards of guardians was to be assumed. All that the committee was required to do was to sink the differences experienced on the Royal Commission on the Poor Law of ten years previous, and suggest how the poor law should be administered by the local authorities.

The Maclean Report, published in 1918, made a number of basic recommendations, which showed that a compromise between the majority and minority positions had been reached in order to provide a basis for reform. The poor law unions and boards of guardians were to be abolished and their responsibilities, institutions, officers, property and liabilities passed to the county and county borough councils. In line with Minority Report thinking poor law services for the sick, mentally deficient and children were to be appropriated under other legislation and integrated with existing county and county borough council services. In addition, the local authorities were required to set up prevention of unemployment and training committees. These were intended to prevent unemployment by rearranging council works and services so as to make a demand on local labour, help people find work through employment exchanges, give educational

training and assist in the migration of labour. At the same time, however, in line with Majority Report thinking, the county and county borough councils were to create home assistance committees, which were to administer out-relief in a manner consistent with principles of less eligibility.[56]

The political imperative of making social reform part of party manifestoes after the War led to a unanimous endorsement of the Maclean Report as a basis for poor law and health care reform. Similarly, there was a parliamentary consensus during the creation of the Ministry of Health in 1919 that it would clearly be inconsistent with the new Ministry's aims to improve health care if it had to supervise a considerable amount of health provision under poor law principles.[57] Duly, Dr Christopher Addison, the first Minister of Health, instructed his officials to draw up detailed proposals for reform on the basis of the Maclean Report. By September 1920 they had produced a draft public health and poor law bill.[58]

Consideration of reform along these lines was threatened by wider debate about the structure of local government. As the Mond memorandum stated in May 1921 "the existing areas notoriously give rise to anomalies in local administration, and it would no doubt be possible

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56 Report of the Maclean Committee (cmd.8917) PP (1918).
57 J.Woodmansee Leland, 'Neville Chamberlain and British Social legislation, 1923-1929' (unpublished Ph.D thesis, Ohio State University, 1970), p.277.
58 For a copy of this draft bill, see PRO HLG 29/262: Papers and correspondence relating to various draft bills on poor law reform 1918-1927.

to argue that no reforms can be fully effective if the areas remain unchanged". Ministry officials, however, quickly discounted a larger reform on the grounds that it would delay reform based upon the Maclean proposals and would arouse considerable hostility from existing local authorities. Consequently, they thought solely in terms of joint action between local authorities and the delegation of functions from upper tier to lower tier authorities as the alternative to a more systematic reform of areas.[59]

An even greater threat was posed by the deliberations of the Consultative Council on Medical and Allied Services, chaired by Lord Dawson, which had been set up under the 1919 Ministry of Health Act. The interim report, which the Council produced in the middle of 1920, as has already been shown, suggested a much more extensive health reform, which was not essentially based upon a reform of local government. Health policy historians have already established that the reaction within the Ministry of Health was to oppose the Dawson Report. Addison had started to envisage a role for implementation of the Maclean Report in a longer-term plans for health care organisation. He wanted to bring about a comprehensive health service by two stages: first, by the unification of local health services; and, secondly, by the extension of national health insurance to dependents. In the former case it was important to

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59 Mond memorandum, p.11. See PRO HLG 68/25: Miscellaneous unallocated papers on poor law reform, 1919-1925.

Addison that provision was free. The Dawson Report, in advocating a general practitioner dominated national health service, clashed with both aims. For it threatened the role of local government in health care, and whilst the Report advocated universal care it did not suggest that it ought to be free.[60] Similarly, senior Ministry officials, pre-eminent amongst which was the first permanent secretary, Sir Robert Morant, had also started to envisage a role for the implementation of the Maclean Report in longer-term plans for health care organisation. Morant considered that the organisation of health care should follow the precedent of the 1902 Education Act, which had concentrated provision in the county and county borough councils. In the short-term poor law health services could be transferred to these authorities, and in the long-term even voluntary hospitals could come under local authority control.[61]

Consequently, Ministry officials acted to discredit the Dawson Report and so end discussion of reform along lines contrary to the Maclean Report. Sir George Newman, the chief medical officer, happily cited the fact that the Dawson Report omitted costings of its proposals.[62] In the economy crisis in central government after the War, therefore, the Dawson Report was not a feasible basis for policy. Ministry opposition then gained

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60 F.Honigsbaum, The Division in British Medicine (1979), pp.73- 75.
61 C.Webster, The Health Services Since the War, vol one, Problems of Health Care: The National Health Service Before 1957 (1988), p.20.
62 Honigsbaum, The Division in British Medicine, p.77.

support from another consultative council on health administration, chaired by Ryland Adkins, and whose membership interestingly included Neville Chamberlain. Its report in September 1920 strongly opposed the Dawson proposal to create a new general health authority in each area, which threatened a county and county borough council role. The Minister and his officials also gained support from the Patient's Council, which had been set up under the Ministry of Health Act. In November 1920 the Patient's Council advocated a comprehensive health service under municipal control. Addison wanted to have the Patient's Council report published so as publicly to take the sting out of Dawson's recommendations.[63] However, Ministry officials opposed this because it also contained proposals to which officials did not wish to be tied. Essentially, the Report advocated the provision of comprehensive local health care whatever the cost. Gaining a reform of local health care, which was allied to this aim, would become very problematical given the Treasury's views on public expenditure.[64]

The Patient's Council report was not published, and given the shared antipathy of Minister and officials to the overall plan outlined in the Dawson Report this too was side-lined from the policy debate. By the autumn of 1920 Ministry officials had effectively limited the discussion of health reform again to that based upon the Maclean Report proposals, which meant that reform would

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63 ibid, p.75.
64 ibid, p.77.

proceed through a reform of local government. They did so because a reform of health care based on the reform of the poor law and provision by local authorities was a development consistent with the now extinct Local Government Board's philosophy of providing social services through local government. As Webster argues, such a reform could build on existing services and institutions which were responsive to central control. By contrast, a reform based on the participation of general practitioners could potentially involve protracted negotiation and be undermined by less than universal participation as general practitioners clung on to their independence to do fee-paying private work.[65] Moreover, it should be noted that many of the medical experts who worked in the Ministry had gained their initial experience as local medical officers rather than as general practitioners or hospital consultants, and were consequently more knowledgeable of and sympathetic to local authority public health care.

In 1920 officials also started to turn their attention to how local government health care could be developed after poor law reform. In September 1920 a committee of public health officials, led by Sir George Newman, contemplated the very great expansion of out-patient work in local authority clinics that would follow after poor law reform. Such clinics were related only to individual services, and provision through them could prove costly.

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65 Webster, The Health Services Since the War, vol one, Problems of Health Care: The National Health Service before 1957, pp.18- 21.

Whilst they opposed the Dawson Report as an overall programme for reform, they adopted the Report's central concept of the general health centre. The concentration of out-patient work in general health centres could reduce material overheads in the long-term. This would improve cost-effectiveness, and, by facilitating the co-ordination of all local authority out-patient care by medical officers, it would also improve the quality of services. Consequently, it is clear also that, once reform on the basis of the Maclean Report had been agreed, Ministry public health officials moved very rapidly towards a vigorous development of the local authority health reform option. The bill for public health and poor law reform had to be shelved in October 1920 in response to Cabinet inertia to reform during the economy, meaning that officials had even more time to develop policy along these lines for the time when reform was more propitious.[66]

The Maclean Report did not contain any proposals for the reform of financial central-local relations. Nor was there any general political imperative for reform by the Ministry of Health. Yet when senior Ministry officials met to consider the financial provisions to be contained in the public health and poor law bill in January 1920 they also addressed the grant question as a whole.[67]

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66 See PRO MH 57/137: minutes of the committee on health organisation and poor law reform. The membership of Newman's committee was composed of F.J.H.Coutts, J.Smith-Whittaker, T.Carnworth and Miss J.H.Turnbull.
67 See PRO HLG 29/260: Poor law reform preliminary papers 1906- 1924 vol one, parts I-VI.

This was based upon their own perceptions of problems in percentage grants. Macleod, the statistical officer, and Francis, a senior officer in the poor law division, shared an antipathy to percentage grants because they did not meet properly the needs of individual local authorities. Francis felt that the earmarking of grants for particular services was unnecessary as it eroded local autonomy and was "the mark of a department which is either weak or dictatorially inclined, or both". The power to retain grant as a punishment for local default he considered to be of little use and only successful in impeding "the attainment of good results by the central authority's other powers, namely those of instruction and warning." He also felt that they involved a mass of correspondence which was of comparatively little use and wasted the time of civil servants.[68]

Francis was to the fore in expressing his hope that grants could become unnecessary by virtue of developing new sources of local income, such as a local income tax. Such policy options were, however, expressly not up for discussion. Instead in their deliberation of alternatives to percentage grants senior officials looked no further than at the Kempe Report and the resulting Finance bill of 1914. This had advocated the block granting of health services, and grant distribution by means of a payment per head of population. It had also suggested the abolition of the assigned revenues and their replacement by a direct exchequer grant, as well as

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68 ibid, Francis to Sir Aubrey Symonds, 15.1.1920.

the abolition of grants paid in compensation for agricultural derating and tithe rent charge rates. The officials outlined a number of options based on these earlier proposals.[69] However, all of them were discarded. Macleod, himself, suggested a number of substantial reasons why no reform of the health grant system could be made.

First, the option to abolish the assigned revenues, merge them with health grants, and distribute a consolidated health block grant at a uniform flat rate on the basis of population met with problems. The grant's success, it was considered, would rest on the provision of an additional sum of £1,000,000 to guarantee any local authority against losses. It was expected that the provision of an additional sum would meet with Treasury opposition. This option was also criticised on the grounds that a grant distributed on the basis of population could not take account of the quality of population and would, therefore, not be directed to areas of greatest need. Even then an alternative option to abolish percentage health grants and replace them with a needs related single consolidated health grant was problematical without rating and valuation reform. Without truly uniform rating and valuation it would be impossible to have a reliable needs related formula for the distribution of the grant to different local authorities.

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69 ibid, note of a conference between Symonds, Macleod and Francis 8.1.1920.

A lesser option of including a new grant to local authorities in respect of transferred poor law health services, which then received no special grant, and distributing the grant on a needs-related basis also met with problems. Macleod considered that the Treasury would oppose any new health grant on the grounds that there had already been a growth in the number of health grants during and after the War, and because Austen Chamberlain, the Chancellor of the Exchequer, had already announced that there would be no increase in exchequer subsidies in aid of rates for the foreseeable future. Macleod set much store by the 1914 Finance bill, which would have resulted in an additional £840,000 being available for local authority health spending. However, he expected that the Treasury would argue that the local authorities had already received the money in relation to increases in existing grants and the moneys to be received under new grants.[70]

Consequently, even in their limited consideration of the finance of local authorities in January 1920 Ministry officials soon abandoned ideas of block grant or needs-related grant reform on the basis of there being little prospect of rating and valuation reform and the expectation of Treasury parsimony. Macleod put aside any further deliberations over a long-term reform of grants and concluded that with regard to poor law reform "the problems relating to exchequer grants, which have to be considered now, would seem to be limited to those

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70 ibid, Macleod to Francis 12.1.1920.

necessarily arising in connection with the transfer from poor law authorities of exchequer grants at present received by them".[71] In February 1920 the office conference considering poor law reform accepted Macleod's conclusions on financial provisions, recognising that they represented "the bare minimum of legislation required".[72] Despite the enthusiasm engendered in some senior officers by the Kempe Report and the 1914 Finance bill for grant reform even this had withered away amidst inertia and pessimism about the prospects for reform.

In this context it may be seen that the true authorship of the Ministry's block grant reform lay not within the Ministry of Health as Rhodes and Stacey have suggested. Instead the initiative was provided by the Treasury. In a manner similar to the Ministry of Health's deliberations of social and local government reform, their deliberations upon the reform of local government finance and central-local financial relations had gone no further than the pre-war advocacy of block grants. After the War, with the prospects of increased local government expenditure and, consequently, increased central aid through percentage grants the Treasury sought to use the new development of finance officers in spending departments to influence those departments to take up the block grant principle. Ernest Strohmenger,

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71 ibid.
72 ibid, report of an office conference convened by Sir Aubrey Symonds 3.2.1923. This legislation would have entailed merely the transfer to local authority health accounts of (a) grants paid to poor law authorities and (b) amounts paid in respect of vagrant lunatics.

the accountant-general in the Ministry of Health, was anxious that the idea of a block grant should not be quietly buried by his colleagues. In a memorandum to Sir Aubrey Symonds, the second secretary, in February 1920, he strongly questioned the assumption that a consolidated health grant should require the provision of new money in order to gain the acceptance of local authorities who might become worse off than they had been under percentage grants. He also advised Symonds that "after further consideration and informal discussion with the Treasury" he was of the view that the grants given under the Agricultural Rates and Tithe Rent Charge Acts should be abolished and included within a new health block grant. An equitable method of distribution could then be found for this new grant. Symonds immediately recognised Strohmenger's views as deriving from "the attitude of the Treasury".[73]

Symonds' response was to instruct Macleod to work out the feasibility of creating a general health grant including also the other grants mentioned by Strohmenger.[74] In his subsequent report, however, Macleod maintained that, desirable as a block grant was, the Treasury could not get one without paying for it. First, he cited the 1888 Local Government Act and the 1914 Finance bill as precedents of the principle that in any general adjustment of exchequer grants no local authority should receive less grant than before and that

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73 ibid, Strohmenger to Symonds, 11.2.1920.
74 ibid, Symonds to Macleod, 11.2.1920.

all local authorities taken together should receive more. He then re-emphasised the necessity of adding £1,000,000 to the grant to ensure that this happened. Distributed on the basis of population, he argued, "the equalising tendency which such a grant is now shown to possess is an additional point in favour of its creation".[75]

In August 1920 Strohmenger responded by presenting Symonds with a draft financial reform to go in to the public health and poor law bill. This advocated a general grant which would replace the percentage health grants, the assigned revenues and the grants made under the Agricultural Rates and Tithe Rent Charge Acts. Strohmenger's major problem in evolving such a grant was to find a basis for giving grants to local authorities for local health services whilst at the same time preserving the relief given to rural areas under the Agricultural Rates Act. He could not find a satisfactory basis and had opted as the best alternative for a subtraction of £1,000,000 from the total sum of discontinued grants and its addition to the rural road grants paid by the Ministry of Transport. This left £6,183,000 for the new general grant in aid of local health services "in place of existing grants and such further sum as the Cabinet may determine".[76]

The latter point was clearly important, for Strohmenger had decided to meet his colleagues halfway in

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75 ibid, Macleod to Symonds, 19.2.1920.
76 PRO MH 57/140: Notes for a Poor Law Reform and Public Health and Poor Law Repeal bill, August 1920, Strohmenger to Symonds 11.8.1920.

order to keep the idea of a block grant in reform considerations. That the Treasury had accepted the need to make short-term bribes to local government in order to get block grant reforms and so economise on grant aid over the long-term is clear from correspondence between Dr Addison and Austen Chamberlain in the autumn of 1920. Despite the growing economy crisis Chamberlain was prepared to agree that "provided that you do not ask me too high a price you may be assured of my hearty support in your contemplated reforms". It is, therefore, reasonable to suggest that Strohmenger had originally accepted the need for a bribe in August with the blessing of senior Treasury officials.[77]

Strohmenger, however, added much to the health block grant reform proposal that was novel. In August he suggested that in order for the grant to be truly equitable its distribution had to be based on much more than population. He suggested that 7s 6d should be paid per head per week on pauper lunatics in each authority, and 4d per head in rural district councils towards public health expenditure as a whole. By September he had started work on a needs-related formula for grant distribution and was testing the potential of assessable value and number of persons per acre as factors in the formula. In September he also advocated that block grant should be fixed for five year periods. He suggested that

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77 PRO T 161/1171/S.3940: Poor law reform proposals leading up to draft Poor Law reform bill, 1927, and memoranda on public assistance 1920-1945, Austen Chamberlain to Addison, 9.11.1920.

the abolition of percentage grants would change the nature of departmental work dramatically in the direction of decentralisation, and warned that the Ministry must keep a power to withhold grant "in the case of a dilatory or supine authority".[78]

Strohmenger's broad principles for a health block grant were incorporated in to the draft public health and poor law bill in August 1920, and although, as has been shown, the bill was dropped in October Strohmenger's proposals were established as the way forward on financial reform.[79] The Treasury had successfully planted the block grant seed in the Ministry of Health's plans for poor law and health reform. This had involved considerable efforts on Strohmenger's part to simply keep on the table the one reform option which central government had considered on financial reform.

This empirically based discussion of the origins of the poor law (health) and block grant reforms in the period after the War provides substantive evidence for the theoretical perspective developed earlier in the chapter. It was not the case that the origins of the reforms lay in the neutral adoption by Ministry of Health officials of a rationally formed consensus on the need for poor law and block grant reform. Rather, it was not until after the First World War, in response to pressures for reform and political directives, that officials broached poor law (health care) or local government

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78 PRO MH 57/140, Strohmenger to Symonds 11.8.1920.
79 ibid, elaboration of a public health and poor law repeal bill by R.W.Harris, 27.8.1920.

reform. Even then they based reform on the Maclean Report in order to maintain a limited reform, which was based on institutions with which they commonly dealt. New policy, therefore, incrementally branched off from existing policy. The context in which reform consideration was initiated, the reasons for the Ministry of Health's enthusiastic adoption of poor law reform and the willful disregard of alternative policy options suggests a rationality for the origins of reform only in terms of bureaucratic concerns in response to a new political climate. Evidence of the adoption within the Ministry of Health of the block grant principle suggests an even less glorious move towards reform. Rather than adopting the principle as a matter of course, officials were prepared to disregard it even before serious consideration had begun. Only the Treasury's incrementalist response to fears about uncontrollable rises in grant aid, consequent upon service expansion to meet popular demands, and Strohmenger's skill in relations with his colleagues at the Ministry of Health, ensured that the principle was adopted. That even then the block grant reform and significant parts of the proposed health reform still faced the bureaucratic forces against change of any kind will be seen in the next chapter.

CHAPTER THREE

THE MINISTRY OF HEALTH PLAN

This chapter reconsiders the view that reform based upon Poor Law and block grant proposals was uncontroversially developed within the Ministry of Health between October 1920 and May 1921; and that the Mond memorandum, written in May 1921, remained a true reflection of the departmental view on reform, which was then placed before Neville Chamberlain in late 1924. It will consider in turn the development of poor law (health care) and exchequer grant reform over the four year period. The basis for reconsideration is provided by further observations on the nature of active bureaucracy. The previous chapter showed how debate upon reform was considered and, in the case of exchequer grant reform, instigated primarily at a bureaucratic level immediately after the First World War. Political scientists have also observed how bureaucratic imperatives even within departments are not homogeneous. Different policy interests are not only institutionalised in different government departments but also in different divisions within government departments. Typically, the British civil service has also been characterised in terms of the divide between generalists and specialists. The former attempt to take a wider view of a Ministry's aims whilst the latter attempt to promote the specific aims of their division. Given that the debate over reform within the Ministry of Health in the early 1920s involved senior

officials with overall responsibility for the Ministry as well as senior officials of the local government and public health divisions and the accountant-general's office, one needs to inquire whether intra-departmental relations also played a part in reform development. The results of such an inquiry again both add to and significantly revise existing understanding of the Ministry of Health's move towards reform in the early 1920s.

1. A REFORM OF LOCAL HEALTH CARE

In October 1920 a departmental committee on health organisation and poor law reform was established. Its members included Sir Arthur Robinson, Morant's successor as permanent secretary, Sir Aubrey Symonds, Sir George Newman, Sir Frederick Willis, a principal assistant secretary, Ernest Stromenger and M.L.Gwyer, the solicitor and legal advisor. The abolition of poor law authorities and the transfer of their responsibilities to county and county borough councils was assumed. Similarly, it was expected that outdoor relief and associated provision would be provided by new home assistance committees, and that poor law medical services would be appropriated under public health legislation. Consequently, the committee's development of health care reform was in the main concerned with the elaboration of policy on how they wished health care to be developed by the local

authorities after poor law reform and the unification of local services.[1]

Important consideration was, first, given to the systematisation of local health responsibilities, which had been accrued on a piecemeal basis during the preceding years. Five general areas of provision were defined. These were general environmental hygiene; direct prevention and treatment of disease, which covered all of the personal medical health services; control of food supply; personal hygiene; and the registration of births. County borough councils, as all-purpose authorities in their areas, could be expected to be responsible for all areas of provision. Questions were asked, however, as to how certain of the different categories of responsibility should be distributed between county council and second tier authorities in the administrative counties.[2] By early November it had been decided that responsibility for general environmental hygiene should remain with the existing statutory authorities, which were primarily the second tier authorities, and be provided for out of rates. However, in practically every other respect health services were to be concentrated under the county councils. This meant, in particular, that those services which were primarily medical in nature, including the isolation

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1. Much of the following discussion is based upon PRO MH 57/137: minutes of the committee on health organisation and poor law reform, October 1920-August 1921.
2. ibid, committee meeting 28.10.1920, paper CHO 7 (1).

hospitals, then a second tier responsibility, should go to the county councils.[3]

Doubts were raised about the effect of a continued second tier authority role in provision on the attainment of efficient health provision within each administrative county. Consequently, with regard to second tier authority provision it was felt that the minimum size for urban areas should be an urban district or borough of 10,000 population, and that the Minister of Health should have a statutory power to combine authorities felt to be "too small for the economic and efficient discharge of any function". Doubts were also raised about the effect of continued second tier authority provision on the attainment of co-ordinated county provision. Consequently, it was felt in respect to the services that second tier authorities provided that there should be general supervisory powers for the county councils. In November 1920, it was agreed by the committee that the county council should "have power, to control by withholding grant aid in case of default by the smaller authority, directly to administer the service in respect of which there was default and charge the cost to the smaller authority."[4] In addition, it was concluded that the county councils should have power to delegate functions to the minor authorities on approval of the Minister and without need to gain the consent of the second tier authority, although in such cases the cost

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3. ibid, committee meeting 11.11.1920, paper CHO 13.
4. ibid, report of committee meeting 2.11.1920.

would continue to be met by the county council so as to maintain the required level of expenditure for effective provision. Delegation was indeed desirable to ensure against the over-centralisation of county health services, but it would not contradict the central principle of the county council becoming the supervisory body for all public health services in the administrative counties.[5]

This prescription of a strong county council role in relation to second tier authority provision was a new departure, and received revision in the Mond memorandum. The capacity for county councils to withhold grant in case of default was removed, and it was felt that the local finance of delegated services should be met by the second tier authorities so as to uphold the principle of chargeability and administration not being divorced. However, in every other respect the idea of the strong county council was kept. The Mond memorandum suggested that the county council be responsible for the general survey of all health services in the administrative county, submit a scheme of provision to the Ministry, exercise supervision over second tier authorities in relation to delegated services and act in place of second tier authorities if they defaulted on the provision of general environmental health services. Thus, Ministry officials developed a clear policy on local health care co-ordination, which effectively meant that county councils would also take on many of the watchdog

5. ibid, non-circulated document, unsigned, 8.11.1920.

responsibilities previously assumed by the central authority.[6]

The Ministry committee perceived that in order to secure health care co-ordination by county and county borough councils the nature of committee responsibility was also important. Ideally the officials wanted the local authorities to create one public health committee to stress that all services were to be seen in relation to one another and so co-ordinated. However, such a committee threatened to become very large and in an added memorandum to the Maclean Report Harry Pritchard, a member of the Maclean Committee and Secretary to the AMC, had objected strongly to the Report's suggestion that local authorities should be required to set up home assistance committees on the grounds that local authorities should have freedom to run their own affairs.[7] Officials took the view that home assistance committees would have to be statutorily required. It would only provoke unnecessary opposition if a single health committee was also to become a statutory requirement.[8] Hence the Mond Memorandum merely stated that a single health committee was desirable and would be promoted to local authorities.[9]

Much consideration also went in to the question of the composition of local authority health committees, if so

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6. Mond memorandum, p.12. See PRO HLG 68/25: Miscellaneous unallocated papers on poor law reform, 1919-1925.
7. Report of the Maclean Committee (cmd.8917) PP (1918).
8. PRO MH 57/137, report of committee meeting, 11.11.1920.
9. Mond memorandum, p.13-14. See PRO HLG 68/25.

created. The consultative council on local health administration suggested that local authority health committees be obliged to co-opt up to 1/4 of their membership from people of "special knowledge and experience of the business transacted by the Authorities".[10] Harris, the committee secretary, suggested that as the health committees would have responsibility for some insured health services as well as public health services after reform, this should be reflected in committee composition. He suggested representation should be given to insured persons to the extent of 3/10. A further 1/10 should be given to the medical profession and the remaining 6/10 left for the councillors.[11] The matter was finally discussed in full in November 1920. It was decided that where a local authority ran public health services through one committee there should be council representation of at least 2/3. Representation for insured persons should be 1/5 or 1/4, with two general practitioners being nominated by the local medical advisory council. Where health care was provided by more than one committee such proportions were to be varied. In their decisions two principles were upheld. First, majority representation was kept for elected members, and indeed the committee decided that co-opted members were not to participate in discussions not related to them. Moreover, the exact proportions of composition in individual health

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10. PRO MH 57/137, report of consultative council, 4.9.1920.
11. ibid, report of committee meeting 8.11.1920.

committees was ultimately to be on the initiation of the local authorities themselves in the administrative schemes they submitted. All of this was written in to the Mond memorandum in May 1921.[12]

The Ministry Committee turned next to the question of how the Ministry would conduct relations with county and county borough councils if exchequer support for health services were provided through a block grant rather than percentage grants. Gone would be the mechanism of checking individual items of expenditure before grant payment as a means to control local authority provision. Instead, the block grant would be paid in advance of expenditure, and relations in theory were to be predicated on the basis of allowing local authorities greater freedom from central control in spending grant aid. Yet, from very early on the committee felt that however desirable local autonomy might be in principle the central department had certain responsibilities which it must provide for. In late October the committee concluded that "It is clear that the extent of the provision cannot be left wholly to local option. With a constantly shifting population-and with certain national commitments-a system of public health services, under the general control of the Ministry of Health must have a large measure of uniformity in the several areas." Hence, even under a new grant system which apparently allowed for greater local autonomy the officials aimed to

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12. ibid, report of committee meeting 11.11.1920.

have a large measure of administrative control over the extent and content of local health authority provision.

From this was born the idea of the local administrative scheme. After poor law reform the local authorities were to be obliged to submit a scheme to the Ministry of Health describing both their existing and newly acquired resources and obligations; and their plans for future provision in each individual service and the co-ordination of all of the health services together. This was to be a first condition of the receipt of exchequer grant. Consequently, each local authority would be reliant upon the acceptance of their administrative scheme by the central department for their receipt of grant. As a result, it gave the central department large scope to reject or amend the content and extent of local policy. In many ways it was felt that this represented a better form of control for the Ministry. Not only would it be less inconvenient and time consuming than the detailed expenditure checking necessary under percentage grants, but it would increase central influence over the planning and co-ordination of health services in each local authority in the long-term, which had not been possible under percentage grant controls. Officials were not thinking in terms of giving local authorities more autonomy in the spending of grant aid, merely a more efficient form of central control.[13]

The Ministry committee turned finally to the question of additional powers and duties for county and county

13. ibid, committee meeting 28.10.1920, paper CHO 7 (1).

borough councils after the enactment of poor law reform. There was some debate about the extension of general practitioner services. Services provided on the insurance principle had existed since the 1911 National Insurance Act and were administered by insurance committees of county and county borough councils. At the same time general practitioner domiciliary services were administered by the poor law authorities for those who could prove eligibility of lack of means. Poor law reform could potentially be used for the extension of the general practitioner domiciliary services to other clients than those then provided for by the poor law. This would mean the greater public employment of general practitioners paid for either from an extension of the insurance principle or out of public funds. In either case the work of insurance committees could be merged with that of public health committees. Such debate, however, was killed off by the continued desire to stick to the least extensive and complex form of reform. Getting involved in protracted negotiations with representatives of the medical profession could still threaten reform of any kind.[14]

The other possibility which arose from poor law reform was an extension of state hospital provision. Poor law residential institutions, which would be transferred to the county and county borough authorities, if appropriated under public health acts could become general hospitals with an unlimited client remit. This

14. Mond memorandum, pp.17-18. See PRO HLG 68/25.

held the potential of making the many vacant poor law infirmary beds available to patients who were not classified as poor. However, Ministry officials were anxious to limit the obligations placed upon local authorities if they appropriated institutions. If they did not then local authorities could become overwhelmed by patient demand which they could not afford to meet, and in the process the voluntary hospitals, which were already experiencing problems, risked becoming extinct. Consequently, in the Mond memorandum officials voiced the intention to make residential provision for the sick poor the only statutory duty placed upon local authorities. Otherwise, it was hoped that in provision for the rest of the population the local authorities would co-operate with the voluntary hospitals in their areas in the creation of an efficient dual system of hospital provision. This could include the provision of subsidies to voluntary hospitals so as to facilitate good provision without placing on the state a permanent responsibility of direct provision.[15]

The decisions on hospital policy as on all the other matters discussed above were essentially uncontroversially resolved by officials in the creation of the Mond memorandum, and remained central parts of the poor law (health care) reform plan throughout the early 1920s. They all appeared again in the proposals for poor law reform submitted to the local authorities by Neville

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15. ibid, pp.18-19.

Chamberlain in 1925.[16] To a large extent they covered technical issues, but in respect of the intention to create strong county council powers over second tier authorities there was the potential for a significant change in central-local relations. Instead of dealing direct with the central authority over most issues the second tier authorities would be under much closer scrutiny from rather nearer at hand. At the same time Ministry officials evolved a new form of central control in block grant relations with county and county borough councils which they clearly intended to provide as much control, though of a more general kind, as they had enjoyed under percentage grants. The two policies taken together suggested that the Ministry could increase control over the provision of health care in county areas; the Ministry could control the county councils, whilst the county councils could aid the Ministry in controlling the second tier authorities. In such a way Ministry officials added to the recommendations of the Maclean Report on the basis of their own imperatives. They intended to ensure that local authorities in the implementation of the local health care reform would not depart from central aims and values in state provision, echoing the original bureaucratic motivations for sticking to the limited local government option for

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16. For a copy of provisional proposals for poor law reform, 1925, see PRO HLG 8/81: Royal Commission on Local Government: constitution, functions and relations of local authorities, and its work in regard to provisional proposals for poor law reform.

health care reform on the basis of existing areas of local government.

In developing the health care reform Ministry officials were not, however, entirely in consensus. Problems arose in October 1920 when it came to Sir George Newman presenting the recommendation of his September health care committee that the provision of out-patient facilities in general health centres be included as an extension of health care powers and duties after poor law reform. Newman accepted that planning a network of general health centres, run by local authorities, would require a very detailed survey of population and communications. However, provisionally, he suggested a total number of five hundred; one for every 60,000 of the population. With this went the acceptance that for services upon which there was a very wide distribution of need, such as infant welfare, there would have to be some special centres. These, however, were to be kept to a minimum; the committee suggested only thirty.[17]

At the same time Newman wrote to Robinson endorsing the aim of the general health centre as "the right line to take". However, he considered that there were two options for practical implementation: first, that the centre be totally within the confines of one building, where out-patient provision for all services would be made; or, secondly, that subsidiary sections be created so that individual services would actually be provided in

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17. PRO MH 57/137, committee meeting 22.10.1920, paper CHO 3.

separate buildings, whilst still being associated with and administered from the general health centre. Newman's personal view was that "No doubt the former is the plan to aim at but in view of the fact that we have got to assimilate many hundreds of clinics already in existence we may find that the latter is the plan which will be adopted in many districts."[18]

Newman's advocacy of general health centres met with a considered response from Ernest Strohmenger. He examined options by which the extra proposal for local authority general health centres could be funded. His main idea was that of funding them on a basis of contributory insurance. However, for this to be practicable insurance would have to be compulsory and universal. Moreover, he calculated the cost of creating a network of centres to be approximately £4 million per annum whilst at the very most insured people would yield only £2 million. Finally, irrespective of such ideas the pauper responsibility would always be that of the local authorities, and with respect to responsibility for all classes of patients in the centres Strohmenger felt that "it may be expected that local authorities would have to face the burden of practically the whole of it at least in the early years." Consequently, Strohmenger's response to the public health division's plans for the future of out-patient care was pessimistic. He expected the financial situation to worsen in the next year and "although Parliament may be induced to find exchequer

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18. ibid, Newman to Robinson, 18.10.1920.

money for wide reaching financial reform such as we contemplate, it is most improbable that they would agree to a new service being forced on local authorities a large part of the cost of which would fall on local rates". Hence, Strohmenger placed major financial considerations in the way of the public health side of the reform getting any more ambitious than it had to be.[19]

After some delay the committee on health organisation and poor law reform, nevertheless, concluded that "it would be a mistake of policy not to include provision for new services as well as for co-ordination of existing services when putting forward a scheme for giving local authorities more freedom from control". Therefore, the committee agreed to the central aims of Newman's committee, and in so doing to the philosophy of the public health division on the future organisation of local authority out-patient provision.[20] In the Mond memorandum health centres were restyled consulting centres, and it was suggested that all out-patient work in relation to venereal diseases, tuberculosis and maternity and child welfare could be there concentrated at much less cost over the long-term than then which pertained in provision through a myriad of single-service clinics. In addition, consulting centres could become the focus for the general practitioner domiciliary services and the services of general practitioners could

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19. ibid, committee meeting 22.11.1920, paper CHO 14.
20. ibid, report of committee meeting 22.11.1920.

be made available for many other specialist forms of provision, such as dentistry. The general practitioners could preserve their independence by being paid by the patient. The main gains would be a more cost-efficient way of providing a better co-ordinated and better quality out-patient service, and the creation of a focus for the interaction of many varied health professionals, who would all gain from working with one another. The memorandum confirmed Newman's suggestion of 500 consulting centres.[21]

The policy of consulting centres, however, remained controversial, and whilst Newman and senior public health officers won the argument between 1920 and 1921, the financial arguments against proved more persuasive thereafter. The grandiose proposals presented in the Mond memorandum were not to be found in the proposals for poor law reform in 1925, and not until 1938, with the opening of the Finsbury Health Centre, were they implemented by a local authority.[22] In the early 1920s financial arguments kept health care reform limited to the unification and development of existing local health care responsibilities. The forces for even greater change through the local authority option for health reform were held at bay.

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21. Mond memorandum, pp.15-17. See PRO HLG 68/25.
22. See PRO HLG 8/81; C.Webster, The Health Services Since the War, vol one, Problems of Health Care: The National Health Service Before 1957 (1988), p.8.

2. AN EXCHEQUER GRANT REFORM, 1920-1921

In November 1920 the Ministry committee on health organisation and poor law reform addressed the development of an exchequer grant reform. By then the Treasury had given consent to Strohmenger's solution to the problem of preserving relief under the Agricultural Rates Acts. £1 million would be subtracted from the discontinued grants and be paid to the county authorities through the road fund. Thus Strohmenger's first paper to the committee was largely a re-iteration of his September proposals with certain ideas now becoming rather more firmly established. The proposed block grant stood at a figure of £6,750,000 plus "such further sum as the Cabinet may determine". Interestingly, he now termed the block grant as being in aid of all health and home assistance services apportioned amongst health authorities. This made no difference to the grant itself, but it does show that Strohmenger was expecting some of the money to be used to support home assistance and not all on health as had previously been the expectation and hope. This is perhaps indicative of the growing post-war awareness of the financial burdens of the poor law. Block grant periods were to be five years. The Minister was to have the power of grant deduction "in the event of the council failing to provide satisfactory services or to administer them efficiently and adequately". This provided an important complement in central control to that provided by the administrative scheme. Finally, he

suggested that the county councils should indeed be given the responsibility for making central government payments to the second tier authorities, thus concurring with the general move towards establishing the county councils as responsible for second tier authority provision. More detailed plans for the payment of grant to joint local authorities, and the payment of interim grants, as well as testing for the composition of the block grant formula, were still in progress.

Strohmenger had, however, revised his thinking in certain respects. For the first time he related financial reform to the strategy necessary to get the whole reform package accepted by local government. He felt that it was very relevant to central desires for "the extension of Health services" that the Ministry "clearly bear in mind that local authorities have long clamoured for a revision of the present grants". Therefore, he made a strong case for block grant reform on the grounds of its attractiveness to local government, and its consequent ability to facilitate local acceptance of poor law reform. He also assumed a maximum addition of £3,000,000 as finance then had to take account of the intention to promote consulting centres. Strohmenger strongly advocated the inclusion of an additional sum in the block grant to ensure acceptance of both poor law and exchequer grant reform. In particular, he noted that the current grants for the poor law and lunacy had been fixed since 1888, in which time expenditure on these services had risen from £9 million to over £30 million. It was

true that on many other services, such as education and the police there had been increases in grants "but in the aggregate they have been accompanied by, if not directly the cause of, increased payment of rates" as well. He concluded that even if a very large increase was made in central grants in the creation of a block grant it "would fail to satisfy the legitimate demands of local authorities for existing services and even if it did satisfy them it would be no more than enough to carry through the financial reform embodied in the scheme without the addition of further services." The transfer of poor law functions did, of course, mean that local authorities would receive new services. Strohmenger concluded, that they would simply become an additional burden on the rates and was therefore "quite impracticable". The chances, therefore, of just £3 million new money in the block grant satisfying local government was slim. Yet it had to be tried. Strohmenger's final comment focused on improving the ministry's argument at the margins. "We ought", he said, "to aim at securing that any savings consequent on the reform shall go in relief of local burdens; the more we can do this the better chance we shall have of carrying the reforms."[23]

Such an analysis suggests strongly that after several months of investigation of the problems of local government finance Strohmenger had come to his own

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23. PRO MH 57/137, committee meeting 22.11.1920, paper CHO 14.

realisation of the inadequacy of a block grant, even including an additional sum and a redistributive formula, to solve them. The block grant was at best a partial solution, but given the climate of reform it was the best that could be proposed. In presenting the block grant proposal in such terms, moreover, Strohmenger also suggested that the principle of the block grant and the additional sum that it would include really represented the least that should be done to solve the problems of local finance, and was the least that should be done to secure local acceptance of poor law reform. Thus, Strohmenger attempted to strengthen the case for the persistence with even the most limited financial reform option of the partial block grant.

The reason for Strohmenger's defence of his block grant proposals soon became clear. Consideration of Strohmenger's proposals earlier in 1920 had taken place among fellow finance officers and senior officials attempting to take a broad view of Ministry aims. However, the committee included Sir George Newman, the chief medical officer. Hence, the side of the Ministry most specifically interested in the development of local health services was able to voice its opinion. Newman had resented Strohmenger's opposition to general health centres and now launched a controversial attack on the block grant proposal, and the proposed new means of central control with which it would be accompanied. Newman "indicated the very serious difficulties" which would arise in the maintenance of standards in the health

services if the form of grant aid was changed. He was duly invited to submit his own paper to the committee on the subject.

Newman submitted his paper in late November. He began by conceding the "two great advantages" of a five year block grant system: that "the state know their liability for a relatively long period of time and the onus is cast upon the authority of preparing and submitting schemes". However, there were two substantial disadvantages as well. First, the removal of the percentage grant in aid system would involve the loss of "a valuable administrative instrument" by which the introduction of services by local authorities could be stimulated. In the same way the grant in being paid on an annual basis provided "an annual incentive to efficiency". A fixed five year block grant would have neither of these advantages.

Secondly, he scorned Strohmenger's idea of grant deduction in cases of mal-provision by a local authority as "to be like docking a horse's tail in order to make him go forward". In an at least mildly sarcastic section he then went on to compare this system under a block grant unfavourably to that which pertained with a percentage grant. Under the percentage grant system "I would attract him by dangling a carrot in front of his nose - if it is forward we want them to go (and I assume that is the case). The one is a vis a tergo and the other is a vis a fronte. From an administrative point of view I prefer the latter. One is able to judge how a local

scheme is developing and to guide it accordingly. The force of this argument of course depends partly on whether National economy and curtailment, or development and expansion are considered to be the more important desideratum for the time being; and partly on the view taken of the degree of responsibility to be assigned to the ministry and the authority respectively". Newman's understanding was that "we are planning for expansion but on an economical basis". Hence, he clearly felt that the continuation of percentage grants was feasible so long as too great an increase in local government spending and exchequer aid did not occur.

In outlining these two problems Newman essentially suggested that local government could not be expected to provide satisfactory health service provision without the stimulus of percentage grants and the close control facilitated by percentage grants. He also attacked the viability of an administrative scheme as the basis of new central-local administrative relationships. He doubted that this would work for its success was "dependent upon the practicability of a local authority knowing how to construct its scheme and the central authority being in a position to examine the scheme and advise upon it", and, even if schemes could be formulated, they were likely to be "of the most general and elastic character". His reasoning was based on the fact that both local and central government were "without the necessary data for ascertaining the needs of an area or the methods of provision". To prove his case he looked at the detailed

examples of maternity welfare, tuberculosis and venereal disease.

With regard to maternity, for instance, there were no reliable figures on which to estimate the number of marriageable women who would be having a child in any one year; and of those who did have children it would be difficult to predict who would use the public medical service, and then which category patient they would be. A particular problem was whether a local authority should try and plan for provision for poor mothers given that they currently showed no interest, and even if they did their numbers would be very hard to predict. His conclusion was that without such data or the possibility of its attainment "we can only go from step to step, the steps differing in different areas owing to various social factors". This piecemeal approach was clearly more compatible with the employment of percentage grants in aid.

He outlined similar problems in predicting tuberculosis needs and formulating a scheme for provision five years in advance. Not only would it be impossible to predict the number of late and middle cases, but, in order for authorities to draft complete schemes, they would need to assume widely accepted systems of treatment. Currently, this was not possible as "the sanatorium system as now practiced is in an experimental and evolutionary stage" in which "medical views vary widely and new forms are being continually introduced". With regard to venereal diseases services such had been

the difficulty of predicting needs and the level of public preparedness to take up local authority treatment that even with only 170 clinics currently in existence the closing of some of them was now being considered. This step was certainly not due to a decline in the disease. In addition, syphilis treatment by salvarsan and gonorrhoea treatment for women were both in experimental stages.

Newman compared the inappropriateness of utilising the administrative scheme idea with regard to health services with the case of education. Here administrative schemes did work effectively precisely because there was the necessary data to estimate needs, and the knowledge and experience of methods that had been well tried and accepted by all concerned. In preventive medicine he had to conclude that there was simply "not yet a sufficient body of fixed knowledge and identical medical experience, accepted by the whole profession, to make it practicable to estimate the needs of an area for 5 years". In the same way government has "not yet had sufficient experience of the willingness of the community to subject itself to the present forms of early treatment suggested". In his summing up Newman was careful to indicate that such problems did not make reform impossible. However, his own views had been backed up by the recent experience of medical officers who had visited Norwich, Reading and Blackburn and came back with little data worth having. He suspected that "Still more will this be true of large County areas". As a result, he

argued that "we cannot now draft on behalf of the Ministry or expect health authorities to draft for local areas, anything like complete schemes for a 5-year period".[24]

The strength of opinion presented in Newman's paper belies the existing conception that Ministry officials neutrally and uncontroversially developed the block grant reform in the early 1920s. For the basis of Newman's argument was the perception of the block grant as being primarily a tool of expenditure control rather than an instrument for improving local health services. Newman clearly saw Strohmenger's advocacy of a block grant as Treasury induced. It was also based on the perception that the controls suggested to go with the block grant would be of significantly less use in relation to influencing local health policies than those which were associated with percentage grants. In the latter respect it is clear that the idea of the block grant as a means of increasing local autonomy was universally absent from the private discourse of Ministry officials. Overall, Newman's views reflected the public health division's desire for no reform of financial central-local relations and instead the perpetuation of percentage grants as the best means of stimulating and controlling local health care development.

Newman's views were discussed with respect but they were not allowed to disrupt the reform package. The committee "agreed that the difficulties, which he felt to

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24. ibid, committee meeting 26.11.1920, paper CHO 19.

exist were not fatal to the block grant system, but pointed to the fact that a satisfactory minimum of services in the scheme as a whole was all that could be secured, and that the schemes submitted by the authorities must be brought to the test of the average present experience."[25] At a later meeting the committee formalised its conclusions. It was agreed that in assessing local authority schemes "the conditions of grant would require such degree of uniformity and standardisation only as would be involved in securing a minimum of services". In addition, only the minimum of efficiency was necessary as a condition for the continuation of grant payment.[26]

In short, the other members of the Committee were forced to admit that the focus of central-local relations under a block grant was only going to allow the central authority to ensure the minimum of provision by a local authority. This was a very low measure to put on the aim of uniform provision, one of the supposedly key aims of the block grant reform, and by far inferior to the administrative power given by a percentage grant which actually enabled the central authority to stimulate the local authority to better provision. The only revision that the committee felt it could make that began to answer Newman's criticisms was that of compelling local authorities to make interim schemes so that five year

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25. ibid, report of committee meeting 26.11.1920.
26. ibid, report of committee meeting 29.11.1920.

schemes that then proved ridiculously inadequate could be avoided.

Obviously, the importance of the block grant reform for other reasons, and the need to set up a package of reform that would get the poor law reform through in particular, were higher priorities than the preservation of central authority to ensure good provision in the localities. Indeed this was confirmed in a meeting of the full committee. In late November "it was agreed that local authorities would be willing to pay a relatively big price to get rid of the Department in details of administration, and that this would be secured by the block grant system". Clearly, therefore,the block grant was seen as a dupe to get the local authorities to accept the whole poor law and health reform, which the committee had been set up to ensure in the first place. The potential costs in terms of, for instance, lost control and unsatisfactory local provision, had to be born.[27]

Consequently, Strohmenger's' proposals for a block grant, now including an additional sum of £5 million, and the central controls to be associated with it were included in the Mond memorandum in May 1921 as an essential part of an integrated Ministry of Health plan to reform the poor law. In the memorandum the arguments that made senior officers such as Sir Arthur Robinson sympathetic to the block grant in the first place were also restated. The block grant would end wasteful detailed control of individual items of expenditure and

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27. ibid, report of committee meeting 26.11.1920.

would bring some measure of equalisation of income between different local authority areas.[28] By May Strohmenger had settled on what he perceived then to be the best means of securing this equalisation. He proposed that the block grant should be distributed to local authorities on the basis of population "but that, in every case where the assessable value per head is below the average, the basis of the apportionment should be increased in the ratio of this deficiency". In making this proposal Strohmenger heeded Macleod's advice in 1920 by committing the Ministry to rating and valuation reform, either before or soon after the introduction of the block grant to ensure reliable figures assessed on a uniform basis. Strohmenger had worked for some time on the possibility of the block grant formula taking in to account the special incidence of sickness, but he had found health statistics an "impracticable" basis for modification of the formula.

The Mond memorandum ended with what the Ministry believed were the main selling points of the block grant reform. It would substantially decentralise the administration of local health services and provide a "definite limitation of exchequer liability for a term of years".[29] Only by reconsidering the evolution of the Ministry of Health plan in the early 1920s does it become clear that these two aims were the product not of a Ministry consensus but grew out of conflict in which the

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28. Mond memorandum, pp.19-24. See PRO HLG 68/25.
29. ibid, p.24.

voices for the limited reform option of the block grant had to shout down the voices against change of any kind.

3. THE BATTLE FOR GRANT REFORM, 1921-1924

The Mond memorandum was not presented to Cabinet in 1921 due to the adverse economic situation, and existing literature suggests that serious consideration of the proposals made therein did not re-occur until late 1924. As has already been shown this was largely true with regard to reform of the poor law and local health care. It would be a fallacy, however, to believe that the controversy over the proposal to introduce a block grant within the Ministry of Health was resolved in 1921 and that it remained the accepted departmental view until the prospect of implementation arrived in 1924. Rather, in the absence of a will for poor law reform, Strohmenger and the accountant-general's office attempted to bring in a block grant reform by itself. Conversely, Newman and other senior public health officers continued to argue against a block grant reform either on its own or as part of an inter-related package with poor law reform. This battle within the Ministry was played out against a changing background of central government attempts to bring public expenditure under control in the economy crisis of the early 1920s through such mediums as the Geddes and Meston Committees.

The first initiative within the Ministry was provided by the internal committee on health and poor law reform,

which continued to meet even after the Mond memorandum had been written. In August 1921 a meeting led by Robinson, Symonds and Strohmenger, senior generalist and finance officers, in the absence of any senior public health officers, discussed the possibility of bringing in a block grant on its own. The proposal was to replace the percentage grants for tuberculosis, venereal disease, blind welfare and maternity and child welfare with a block grant as an "installment of reform". The county and county borough councils were to be responsible for the distribution of the block grant "and entrusted with full control over the detailed administration of the services".[30] However, the proposal was soon dropped after the committee had had discussions with H.O.Stuchbury, the senior official responsible for maternity and child welfare in the public health division, and had come "to the conclusion that any legislation for the purpose of bringing about the suggested change would provoke opposition not less serious than any opposition likely to be encountered if it were attempted to give effect to the comprehensive scheme of reform".[31]

The source of opposition was not explicitly made clear. The Treasury would have supported a block grant by itself even had it meant the inclusion of an additional sum, for it would have helped limit the extent of grant aid over the long-term. Similarly, all the

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30. PRO MH 57/137, report of committee meeting 9.8.1921.
31. ibid

evidence of earlier Ministry consideration suggests that it was believed that the local authorities would have welcomed a block grant reform by itself in order to be rid of petty central controls. Consequently, it would be most logical to suggest that Stuchbury was voicing again the opposition of the public health division in general to a grant reform, and his own opposition to the inclusion of maternity and child welfare in the block grant in particular. Maternity and child welfare was the most recently initiated service and was arguably in most need still of the stimulus to development provided by a percentage grant. It is relevant to note also that senior public health officers now felt no obligation to sacrifice their own service priorities on grants for the sake of health care development through poor law reform. They could focus unambiguously on opposition to a grant reform.

In August 1921 such opposition proved prohibitive to reform. However, Sir Arthur Robinson was eager to stop inertia over percentage grants from setting in. He initiated an inquiry in to the duplication of inspection by officers and gave "instruction to the divisions concerned and the A-G [Strohmenger] as to the possibility of relaxing the detailed control now exercised by the Department over expenditure on grant-aided services".[32] That the irritation in both central and local government over the detailed controls associated with percentage grants persisted throughout the 1920s is evidence of the

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32. ibid

limited success, if even that, of Robinson's initiative in 1921. Yet, the fact that it was attempted at all shows that in the search for grant reform Strohmenger and the accountant general's office had the powerful support of the permanent secretary.

August 1921 also saw the creation of the Geddes Committee, whose brief was to recommend economies in public expenditure. The Ministry's evidence to the Committee argued against the perpetuation of percentage grants and "clearly implied that in our judgement these health services have now so far established themselves that, as a general rule, they will be maintained and extended by local authorities under local pressure" and, therefore, no longer needed the financial incentive of a percentage grant.[33] This was expressed as a Ministry view, but clearly contradicted Newman's view in the Ministry committee on health organisation and poor law reform earlier in the year. Nevertheless, the Ministry's evidence provided the basis for the Geddes Committee to recommend the fixing of the health grants for 1922/1923 at the level of grants paid for 1921/1922, and their distribution by means of rationing. This the Ministry agreed to, and indeed in February 1922 Robinson was able to remark that implementation had been carried out "with nothing in the nature of a serious protest from the local authorities" and without damaging local provision. Furthermore, he commented that "the policy of using the

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33. PRO HLG 52/342: Meston Committee-Block Grants, papers of Sir Arthur Robinson, 1922. Robinson to Sir Alfred Mond, 25.2.1922., p.2

present financial pressure to bring in the principle of a fixed grant has been justified".[34] Fixed grant rationing had, therefore, achieved an incremental step towards one of the central principles of a block grant.

Robinson did not, however, perceive fixed grant rationing as a permanent solution to the question of grant reform. He informed Sir Alfred Mond, the then Minister of Health, in February 1922, that whilst it provided a means of controlling grant aid and was not unpopular with local government, it still entailed detailed checking of individual items of local expenditure. "Nor", he continued, "have we solved except in the most general way and in regard to parts only of the services, the problem of bringing the state contribution in to relation with the ascertained health needs of the authority or the area. Accordingly, though we may have to and may be able to carry on for a year or two on the present arrangements, I cannot myself regard them as a permanent substitute for the system of percentage grants, and the question of such a substitute still confronts us".[35]

The Geddes Committee made a further recommendation for the permanent abolition of health percentage grants and their replacement by a block grant. However, this received a cautious response from the Ministry. The Ministry had a policy of block grant reform set out in the Mond memorandum, which Robinson confidently described

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34. ibid, p.5.
35. ibid

as "our departmental view of what the permanent system should be". Yet, a block grant reform carried out in the wake of the Geddes Committee was likely to be hasty and framed with economy as the highest priority. Moreover, the Ministry's block grant policy was, of course, "inextricably bound up with a reorganisation of the whole system of local government consequent on the abolition of the poor law". Robinson took it that such a "reorganisation is not practical politics now or likely to be in the near future".[36] Hence, the Ministry of Health in a manner similar to other spending departments responsible for percentage grant relations with local authorities did not endorse the Geddes recommendation for a block grant. This conflict resulted in the creation of the Meston Committee in 1922 to further investigate the grant question.

The Ministry again adopted a cautious approach. It was prescribed by the desire to safeguard the integrated poor law-exchequer grant reform plan. Robinson kept this out of the terms of reference of the Meston Committee, and adopted a minimalist approach to giving evidence. Officials would merely describe the principles of existing health grants and would only volunteer views on what they felt ought to be the principles which guide all central grants after the local authority associations had given evidence, and only when specifically asked to. However, Robinson was obliged to write to all senior officers asking them to prepare evidence. This provided

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36. ibid, p.6.

a new opportunity for the public health division to argue their case for the continuation of percentage grants and the dropping of a block grant reform either on its own or in association with poor law reform.[37]

H.A.de Montmorency, the senior official responsible for tuberculosis, was particularly upset by the Geddes Report's damning description of the percentage grant as a "money spinning device". On the contrary, he claimed, it "has undoubtedly proved effective in aiding the development of the services to which it has been applied and it is permissible to assume that no other form of financial assistance would have given equally satisfactory results". He also suggested that removal now of a percentage grant could have adverse consequences. "Local authorities are under no statutory obligation to make any provision at all, and there is ground for fearing that, in some areas at all events, the withdrawal of the percentage grant would be followed by an appreciable relaxation of local effort and a consequent reduction in the standard of provision". He admitted that provision in some areas was clearly inadequate and felt that "it would be unfortunate if the Department were permanently deprived of the power to stimulate backward authorities to a policy of greater efficiency".

De Montmorency then went on to question the appropriateness of a block grant to funding tuberculosis services. "The state", he felt, "cannot regard the

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37. ibid, Robinson to Maclachlan and Stuchbury 17.2.1922.

problem of tuberculosis as a mere aggregation of local problems towards the solution of which it need make no other contribution than that of an annual financial dole". The service was still in its infancy, and its development had been retarded by the effects of the War and the post-War economies. Consequently, he felt that local authorities "will require for some time to come the expert guidance which a central department is in a position to supply", guidance that could be best given in a system of central-local relations based upon percentage grants.

At the same time he criticised the concept of having fixed grants for five years in relation to aiding local tuberculosis services. To fix such grants on an equitable basis would require knowledge of the cost of treatment, the incidence of the disease in different areas, the extent of local provision, and the nature of the service provided. De Montmorency pointed out that prices had been unstable since the First World War and could be expected to remain so. Thus the cost of treatment over a five year period could not be predicted with any certainty. Similarly, there was little way of telling whether new forms of treatment, such as the village settlement, would come in and replace residential treatment. Finally, he suggested that the evaluation of the extent of local provision, and the creation of a uniform standard of provision throughout the country was impossible since there were such "wide variations".[38]

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38. ibid, minute by de Montmorency 10.4.1922.

A.B.Maclachlan, the senior official responsible for venereal disease services, agreed with his colleague. There were great variations in the provision of both tuberculosis and venereal disease services, which could be best made good by the continuing stimulus and close control provided by percentage grants. He believed that the formula for distribution of a block grant would always be grossly unfair unless some account was taken of local expenditure and the local incidence of venereal disease. Like de Montmorency he perceived the block grant as principally a money saving device, and if forced to advise change from percentage grants preferred even the continuation of the temporary system of fixed grant rationing to a block grant.[39]

Maclachlan and de Montmorency received further support from Stuchbury, who argued strenuously against the inclusion of maternity and child welfare under any proposed block grant. It could not take account of the great variations in types of work, costs of each item of work, the degree of voluntary agency involvement, the cost of food and milk, and the complexity of capitation grants. As it would be fixed for periods of five years nor could it respond to the great variations in local need for financial assistance. For, he claimed, "M & CW expenditure is to a certain extent explosive and intermittent: a widespread outbreak of measles will close the centres and day nurseries and fill the hospitals and necessitate largely increased payments for nursing: the

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39. ibid, minute by Maclachlan 10.4.1922.

cost of milk rises steeply with a local strike or trade depression etc".

Stuchbury also cast doubt on the redistributive aim of the block grant. He accepted that if a grant was allocated on the basis of helping all local authorities to meet health provision standards prescribed by the Ministry then it would perhaps be right to allocate grant on the basis of expenditure "with additions for backward districts". However, such a grant would also entail "deductions for the more active districts, which it would be difficult to justify in practice". Indeed Stuchbury dismissed all potential factors, including population and assessable value, as a valid basis for a block grant formula. For they would not prove logically consistent between different residential areas. He was personally of the view that any new basis for grant distribution "must give results as near as possible to the present allocation on expenditure, if it is to be acceptable to local authorities", which suggested that even if a reform was implemented it should not really change anything.

At the same time as attacking the appropriateness of aiding local maternity and child welfare services through a block grant, he actively endorsed the continuation of aid through a percentage grant. Much had been said about the percentage grant encouraging extravagance. Yet, so Stuchbury argued, this was not the case with maternity and child welfare. Under the 1918 Maternity and Child Welfare Act the Minister had been given powers to prevent extravagance, which had been duly used. He argued that

"it will be difficult to get local authorities to fill up the numerous gaps in their schemes without such an inducement as the percentage grant affords". In particular "opportunities for development often occur suddenly and unexpectedly", such as the bequeathment of a house as a maternity home. In these cases "unless the Department was in a position to promise an addition to the grant the offer might be lost". He also argued the importance of percentage grant funding to the continued encouragement of voluntary society provision in local areas. Without the assurance of a grant for half of their expenditure from local authorities their involvement may be undermined.[40]

The arguments of Stuchbury as well as those of De Montmorency and Maclachlan in relation to the disadvantages of block grant funding and the advantages of percentage grant funding for securing local health development in accord with Ministry aims were endorsed by Sir George Newman in his paper in May 1922. He felt that the advantages of continuing with percentage grants had been put "very clearly and fairly". He himself felt that "for new services such as school medical service, tuberculosis, venereal disease and maternity and child welfare in which local authorities require both incentive and detailed guidance I doubt if, under existing circumstances of local government, there has been a better system than grants in aid. I doubt if any other system would have been workable or able to "deliver the

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40. ibid, minute by Stuchbury 17.3.1922.

goods" in view of the absence of statutory compulsory powers".

However, Newman, alive to the strong forces massing in favour of a reform of grants, searched for a compromise. He accepted that percentage grants tended to encourage unequal standards in provision and that economy in grant aid was a legitimate aim of government. Hence, he endorsed the continuation of the fixed grant rationing system as a compromise that would retain the essential percentage basis whilst making the desired changes, and "without upsetting the local authority unduly or seriously disturbing the medical services, either in kind or degree". He also made encouraging comments about the introduction of a block grant but stressed that this should be an option which should be introduced in the slightly longer-term once the local health services, most of which were recent in origin, had got off the ground under the aegis of percentage grants or rationed fixed percentage grants. He helpfully suggested that the concept of a block grant "should receive our continuous attention during the next two or three years".[41]

Newman's efforts to produce a compromise and delay a block grant reform, however, came up against equally strong lobbying from Strohmenger. He replied to Robinson's request for views on which to base evidence for the Meston Committee with a new plan to bring in a block grant for the public health services on its own. In a paper of April 1922 he argued for an omnibus grant

41. ibid, minute by Newman 15.5.1922.

to be voted for all grant aided public health services to the equivalent of the aggregate public health grants voted for 1922/1923. He felt it "essential that one grant only should be given in order to obtain some elasticity between the services and, further it would involve a substantial re-organisation of the office, especially of the medical division". In other words, Strohmenger intended that under an omnibus grant detailed central control would largely disappear. He also suggested that the grant would be fixed for three years. The grant would be distributed to individual local authorities in line with existing grant aid, although this would remain provisional until detailed inquiries had been carried out on local health provision during the next two years. He clearly meant that the grant should in due course be distributed on the basis of greater knowledge of local authority needs. However, herein also lay the origin of central control by means of survey to give officials the necessary information on which to ascertain whether local authorities were using grant aid wisely. Strohmenger's proposal was overall essentially a block grant for health services based on present levels of expenditure.[42]

At the same time Sir Arthur Robinson came under pressure from Sir George Barstow, the Treasury official responsible for local government finance. In late May Barstow sent Robinson his notes for ministerial briefing. These showed that the Treasury aim was to reduce central

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42. ibid, minute by Strohmenger 21.4.1922.

finance to local authorities through the introduction of a block grant to cover all local authority grant-aided services. The overriding priority of the Treasury's desire for expenditure control is born out by his statement that the whole point of a block grant was "to get rid of the disastrous inducement to expenditure which the knowledge that only a percentage will require to be paid for locally brings to the local authority", and that "it would be a matter of comparative indifference to the Treasury" upon which basis the block grant was then distributed to local authorities. Barstow, however, was aware that at that time such a block grant "would excite very strong local opposition. In seeking the ideal solution from the exchequer point of view, we might lose the whole game". Consequently, he concluded that for the time being the Treasury would be "content with stereotyping grants at figures no higher than they have already reached and thus stemming the rising tide of government grants". This appeared to give some basis for believing that Strohmenger's proposed omnibus health grant might receive Treasury support.[43]

Consequently, Robinson, ignoring the statements of Newman and the senior officials of the public health division, recommended Strohmenger's "very suggestive memorandum" to Sir Alfred Mond in May 1922.[44] The immediate response was encouraging. Douglas Veale, Mond's personal secretary, informed the Minister on the

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43. ibid, copy of Barstow's notes for briefing Churchill before meeting Lord Meston 27.5.1922.
44. ibid, Robinson to Mond 25.2.1922.

content of all the internal Ministry discussion since the beginning of the year. He expressed his objections to the percentage grant system and found Stromenger's proposal for an omnibus grant and its method of allocation "attractive" and "worthy of consideration". Yet, Veale subsequently advised Robinson to take the idea no further with Mond until after the parliamentary recess.[45] Clearly, the Minister did not consider reform a matter of urgency, and indeed this evidence is consistent with later comments made by Robinson to Neville Chamberlain that Mond was not the most zealously reforming or conscientious of ministers, and was often hard to locate.

Nevertheless, senior officials of the Ministry of Health were now attempting to promote a new proposal for interim grant reform. It excited renewed defence of percentage grants from senior public health officials. Sir Thomas Hughes of the Welsh Board of Health, and previously a member of the Kempe Committee, expressed concern over the possible implementation of an omnibus health grant in Wales. In particular, he was concerned that the grant reform would jeopardise the Board's agreement with the King Edward VII Welsh National Memorial Association, under which the latter provided tuberculosis services.[46] Back in Whitehall, Sir Frederick Willis, Chairman of the Board of Control, which was attached to the Ministry of Health and was

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45. ibid, Veale to Robinson 31.5.1922.
46. ibid, Sir Thomas Hughes to Robinson 28.6.1922.

responsible for local authority mental deficiency services, argued against the inclusion of the mental deficiency grant in the proposed grant. Mental deficiency had only been a responsibility of local authorities since 1914 and very little had been done before 1918. Even since then encouragement to spend had been followed by retrenchment and there were very wide variations in development. The service was still in its infancy and Willis believed that the percentage grant was still needed to stimulate activity. Moreover, there were very great variations in the cost of maintaining patients in institutions, as this was generally based upon co-operation with local charities. If a uniform grant were to be introduced the central contribution to the local cost of patients would frequently be either too low or too high. Neither the extent or content of provision had settled down sufficiently to support the idea that the necessary central aid could be predicted and put in to a fixed consolidated health grant.[47]

New papers were also written by Maclachlan and Stuchbury to Robinson in July 1922. Stuchbury heeded the warning of Mosse, the Ministry of Health official who was serving as secretary to the Meston Committee, that Lord Meston was interested in instances of local authority extravagance in the usage of percentage grants and how they were dealt with. He revealed that eight investigations of local authorities had recently been made, which had shown that there was considerable

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47. ibid, Sir F.J.Willis to Robinson 30.6.1922.

extravagance in three cases; Bradford, Nottingham and Stepney. In each case the very conduct of the investigation or central pressure had remedied the extravagance. Hence, he upheld his earlier claim that financial control was not only potentially better under a percentage grant than a block grant but was indeed a reality.[48] Sir George Newman appeared now to have accepted reform, but the tenor of his comments in a minute of late June suggested that he was no willing participant in the Ministry consensus for an omnibus health grant. He clearly found it irritating that the proponents of any block grant policy should assume that it would carry with it a reduction in the medical supervision of local authority health services. On the contrary, he felt that "obviously we should be saved a certain amount of detailed consideration of expenditure, but that would not absolve us from an adequate supervision of medical and health questions". This he mentioned to "avoid misunderstanding".[49]

The flurry of internal papers arguing against Strohmenger's omnibus health grant were received by Robinson without enthusiasm. Willis' paper on mental deficiency was handed on to Strohmenger, who reacted by suggesting that there was "no insuperable difficulty in abandoning the percentage grant even in this case". He suggested that, simply, the local authorities would be obliged as with other health services, to make a scheme

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48. ibid, Stuchbury and Maclachlan to Robinson 8.7.1922.
49. ibid, minute by Newman 29.6.1922.

of mental deficiency needs for the next three years together with an estimation of cost. The Board of Control would then do the same for each local authority on the basis of accounts and inquiries and on the assumption of the need only to maintain the existing service without expansion or retrenchment. The final grant would then be equivalent to 1/2 of the assessments made by local and central government with the addition of a capitation payment each year on the actual excess number of new urgent cases over deaths and discharges. The grant would then become subject to the same conditions as the consolidated grant.[50]

Strohmenger remained firm on his grant proposal and suggested that it would be distributed to local authorities in accord with local need as much as possible, even though he recognised that this would not be perfect until rating and valuation reform had also been undertaken.[51] Robinson remained behind Strohmenger and the proposal for an omnibus health grant formed the main text for the Ministry's draft evidence to the Meston Committee in July 1922. The grant was to be a consolidated health grant equivalent to the aggregate of grants voted for 1922/1923. From this a single consolidated grant would be given to each local authority which was roughly consistent with what they were then currently receiving. To gain the grant local authorities would have to submit schemes of work for the next three

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50. ibid, Strohmenger to Willis 7.7.1922.
51. ibid, Strohmenger to Robinson 8.6.1922.

years to the Ministry, which were to embody economies where possible but should also contain provision for essential developments. The Ministry would then have the power to make grant assessment according to its opinion of the scheme, and would continue to consider grant levels with reference to inquiries in to local authority and voluntary agency work. Robinson's triumphant conclusion to the draft was that "under this system, control of detail centrally would to a large extent disappear", but good local provision would be ensured through periodical inspection and audit.[52]

However, by August Ministry officials had got cold feet. As a result of a further paper by Robinson in which he laid out the pros and cons of the percentage grant system and the principles of the grant reform contained in the Mond memorandum a meeting was held between Robinson, Newman, Strohmenger and Stuchbury. A whole series of questions were posited about the working of percentage grants in practice, which suggested that the officials, particularly Robinson, had become wary of making grand policy for grant reform in the absence of detailed knowledge of that which they were seeking to replace. Robinson announced at the end of the meeting that he needed "clear guidance on the existing facts examined on the spot and reported on with the various standpoints of administration, medicine and finance".

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52. ibid, Ministry of Health evidence to the Meston Committee on exchequer grants in respect of locally administered services. Draft circulated amongst Ministry of Health officials by Robinson 4.7.1922.

Duly a one year programme of inspection of the tuberculosis, maternity and child welfare and mental deficiency services provided in a number of local authorities was laid out. Stuchbury was made responsible for its administration. Newman and Strohmenger were to put forward nominees to inspect the financial and medical issues involved.[53]

In effect this meeting had witnessed Robinson drawing the Ministry back from the brink of proposing a health block grant without poor law reform to the Meston Committee. It may be that Robinson had simply become uncertain of the correctness of such a reform in the absence of detailed knowledge. However, the lack of solid support from his Minister, and the logic of the Mond memorandum that a block grant brought in at the same time as poor law reform was vital to the latter's successful acceptance by local government, must have both featured very heavily in his thinking. In this context the creation of new lines of inquiry in to the working of percentage grants may be seen as a means of ending the conflict amongst senior officials whilst still keeping the Ministry committed in principle to a block grant as laid out in the Mond memorandum, to which Robinson was personally committed. The Ministry's advocacy of a partial health grant, but one only allied to poor law reform, was the one which was finally put in evidence to the Meston Committee in 1923.

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53. ibid, untitled paper and discussion notes by Robinson 11.8.1922.

As has already been shown the Meston Committee achieved little in the way of progression towards reform, and between 1923 and 1924 Ministry officials did not reconsider its position on grants. Evidence of the one year programme of inspection in to the working of percentage grants is not traceable. However, when Neville Chamberlain took office in late 1924 and expressed his willingness to carry poor law reform internal Ministry discussion was renewed. The official Ministry advocacy of a block grant allied to poor law reform was contained in the Mond memorandum, but it is clear that the persistent opposition of Sir George Newman and other senior public health officials to a block grant reform had helped to undermine the Ministry's commitment to the memorandum. Strohmenger, writing to Sir Arthur Robinson and Sir Aubrey Symonds in December 1924 on the subject of poor law reform, reminded them that they had reserved the question of the financial effect of the proposals for further discussion. He duly set about convincing them that block grant reform was necessary by detailing the results of a speculative analysis of the financial cost to the exchequer of the transfer of poor law services and their administration under public health and other acts if a system of percentage grants was retained. Here it is important to note that such services under poor law authorities did not rank for grant aid. If they were transferred to county and county borough councils and appropriated under other legislation

then they would become eligible for percentage grant aid.[54]

Macleod had made the first calculations and concluded that reform on this basis would cost the exchequer an additional £9,456,000 a year in percentage grant aid. Two reductions of this figure were possible. If, as a result of this increase in grants there was an equivalent decrease in county and county borough rates then grants under the terms of the 1923 Agricultural Rates Act would fall by £256,000. More significantly, if the exceptional grant for pauper lunatics remained on the basis of 4s per head after transfer to the local authorities rather than become based instead on 50% of net expenditure, which was the grant aid that the local authorities enjoyed, then the overall increase in exchequer grant aid as a result of poor law reform could be reduced to £6,330,000.[55] Francis had considered that "there seems good ground for accepting all the data postulated by Mr Macleod". However, he felt that the county and county borough councils would make a strong case for provision for transferred pauper lunatics to be based on the same system of percentage grant aid as their existing lunatics. The Ministry would find it very difficult to construct an argument in opposition. Hence, Francis suggested that the cost to the exchequer in additional percentage grant aid consequent upon poor law reform would most probably be up around £9,000,000. Francis

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54. PRO HLG 68/25, Strohmenger to Symonds and Robinson 2.12.1924.
55. ibid, Macleod to Francis 12.11.1924

found this figure "startling" and further stated that "once the general principle of transferring work from the poor law authorities to grant aided authorities is admitted, I am disposed to think that the charge on the state would prove to be greater rather than less than the estimated amount".[56]

Macleod did some further calculations based upon limiting the potential for pauper education services being allowed to rank for grant aid if appropriated under education acts, which slightly reduced the extra cost to the exchequer of poor law reform. He also calculated that if there were no appropriation of transferred poor law services under public health or education acts then the extra cost to the exchequer in percentage grant aid would be down to a total of £2,750,000. However, were this to happen much of the social content of the poor law reform would be lost. Only by appropriation could local services be unified and provided at a better standard for the whole community.[57]

Consequently, in his paper in December 1924 Strohmenger stated that "without elaborate separation of accounts and imposition of onerous conditions the transfer of the duties and powers of the guardians and the consequential absorption in to the ordinary services of the local authorities of the poor law duties so far as they were covered by these services would add materially to the present percentage grants from the exchequer so

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56. ibid, Francis to Strohmenger and Sir Aubrey Symonds 13.11.1924.
57. ibid, Strohmenger to Symonds and Robinson 2.12.1924.

far as the services were state-aided". He also felt that it was probably inevitable that there would be extensions of existing services which would ultimately make the figure of additional cost more in the order of Macleod's initial estimates rather than his later ones. He continued by stating that "whatever the figure may be it seems almost certain that it will be so considerable as to make the cost of transfer of the poor law by itself almost prohibitive and to constitute an extremely strong case for poor law reform to be accompanied by some measure of financial reform". He believed that the positive arguments in favour of a block grant reform had been very well made in the Mond memorandum, and the analysis of the cost of a poor law reform based upon the continuation of percentage grants had merely confirmed the overwhelming weight of argument from an exchequer point of view in favour of poor law reform being accompanied by a block grant reform. It was not only a good thing in itself but was the only financially viable option by which the Ministry could get the poor law reform on to the statute books.[58]

Strohmenger advocated a block grant reform based upon the proposals included in the Mond memorandum to Robinson and Symonds which they duly accepted. The integrated poor law-block grant reform plan was presented whole to Chamberlain later in the month, and the Mond memorandum proposals for a block grant were to be found re-iterated in Chamberlain's poor law reform proposals circulated to

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58. ibid

local authorities in 1925. However, as has been shown, the presentation of these proposals to Chamberlain did not represent the mere promotion of a Ministry view which had remained unchallenged and gathering dust since 1921. Certain aspects of the poor law (health care) reform had been novelly formulated within the Ministry and had aroused certain intra-departmental controversy. But this was as nothing compared with the block grant. The block grant reform option had aroused considerable controversy within the Ministry of Health both before and after the creation of the Mond memorandum. The accountant-general's office and the chief medical officer, backed up by the public health division, had been in semi-continuous conflict, and there had been numerous attempts to initiate a block grant on its own which were foiled by the public health division. In late 1924 the battle for a block grant reform was still being waged and was only won by Strohmenger through his sheer tenacity to win the argument and so achieve that which the Treasury had wanted since the end of the War. Ironically, Strohmenger's victory within the Ministry of Health was not to be rewarded with enactment for another five years because of the Treasury's greed for a block grant to cover all local authority aided services.

That Strohmenger had still to win the case for the block grant reform in late 1924 raises the question of why he no longer had the unequivocal support of the permanent secretary, Sir Arthur Robinson. In 1921 and again in 1922 he had stressed his adherence to block

grant reform related to poor law reform. However, in August 1922 he had put a stop to Strohmenger's plan for an omnibus health grant on its own despite having been initially in favour, and the fact that the question of grant reform as part of poor law reform had apparently been left open for resolution by Strohmenger in late 1924 suggests that even Robinson's support for a block grant reform as part of a larger reform had wavered. As will be shown in the next chapter that the block grant remained part of the reform package owed much to the political imperative of Neville Chamberlain, and the position taken by Robinson and other officials on both poor law and exchequer grant reform changed in response to the changing attitudes of the local authority associations. It is to the forces acting from outside on the making of policy within the bureaucratic elite that the thesis now turns.

CHAPTER FOUR

THE ACHIEVEMENT OF REFORM

The first part of this chapter reconsiders the view that the liberal reformist motivations of Neville Chamberlain combined with his political acumen was instrumental in achieving the enactment of the reforms developed within the Ministry of Health in the early 1920s. That Chamberlain was a skilful politician who finally helped to win reform in Cabinet is not to be doubted but his liberal reformist motivations should come more under scrutiny. The basis for such inquiry is provided by the extension of the theoretical re- conceptualisation of the rationality and neutrality of civil servants to that of politicians. Chamberlain's pursuit of poor law reform in the late 1920s has been characterised already by Crowther as implicitly the politically motivated preservation of a system of social policy which serves the interests of one class over another.[1] It should, therefore, be asked if Chamberlain's motivations for pursuing reform, and then the limited reform options chosen by the Ministry of Health, should be characterised as stemming from shared values, aims and approach to policy with the bureaucratic elite; and whether Chamberlain should be merely seen as a highly competent cipher of that elite's aims. Moreover, Crowther's assessment suggests the need for further inquiry in to the party political motivations of Neville

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1. M.A.Crowther, The Workhouse System 1834-1929 (1981), pp.102-103. See also M.A.Crowther, British Social Policy 1914-1939 (1988), p.49.

Chamberlain in promoting reform. Similarly, it must also be asked whether perceptions of the values and aims of politicians influenced the bureaucratic response to political efforts to carry reform. An investigation of answers to these questions is made in the first part of the chapter.

The second and third parts of the chapter reconsider the view that Chamberlain and the Ministry of Health achieved reform that met the plurality of interests. This is based upon the observation of political scientists that those within the governing elite have power over the access to be given to interests outside government to the reform process. The management of wider debate that this facilitates allows those within government to ensure that reform proposals do not go further than they would like, whilst at the same time being able to appease major interests, suggesting the achievement of reform in the general interest. The explicit intention to appease those interests, which have the power to control the voice of those not catered for by reform, would suggest the presence of corporatist arrangements at an individual policy level. Such observations suggest how reform may not be made successful in terms of the whole plurality of interests through fully open negotiation and compromise. Rather reform is only made successful in terms of a limited number of interests through a still relatively closed process of negotiation and compromise. Successful appeasement of the interests given access to policy

influence gives resulting policy only the appearance of full pluralism.

This line of inquiry is further based upon the theory of the inter-governmental network, which provides a rationale for why and how specifically the local authority associations may be taken account of and accessed in to the formulation of reform. The application of the concept of the inter-governmental network to the inter-war reform process appears appropriate, given the high level of financial and service inter-dependence between central and local government. This suggests an important additional basis for inquiry in to those interests which were allowed to influence local government reform in the 1920s, and the implications they had for the nature of the final reforms. This basis for inquiry is fully removed from the high politics focus of previous major commentators, such as Dilks.

1. THE POLITICAL IMPERATIVE FOR REFORM

The context to Neville Chamberlain's pursuit of local government reform may be seen in a similar context to that which governed the bureaucracy's shift to policy reform in the early 1920s. The first stimulus to reform development was provided by general perceptions of expectations for reform outside government, and changed perceptions, therefore, of the response that political parties should make in order to win votes. This came

initially before the First World War, when the majority of the working classes were excluded from the franchise but, nevertheless, the Liberal party were gaining considerable electoral success from policies of social reform.[2] Moves were made within the Conservative party to develop social reform policies which were consistent with party philosophy but could compete. The Unionist Social Reform Committee was established in 1910 in order to evolve long-term policies. The proposals that the Committee evolved were considered radical by the Conservative party leadership at the time and efforts were made to distance the party from close identification with them. The party essentially remained committed to principles of laissez faire. However, the Committee became a breeding ground for party reform ideas and politicians who considered their implementation vital for maintaining electoral success. Prominent amongst these was Neville Chamberlain.[3]

Conservative perceptions of the need to be seen as a party of social reform grew even stronger in the period after the First World War. The extension of the franchise to include many more of the working classes provided the potential for the rise of the Labour party both at a national and local government level. Indeed Labour captured control of an increasing number of local authorities, particularly boards of guardians and non-

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2. See J.R.Hay, The Origins of the Liberal Welfare Reforms, 1906-1914 (1975).
3. For a brief discussion see J.Ramsden, The Making of Conservative Party Policy, The Conservative Research Department Since 1929 (1980), pp.12-23.

county borough and urban district councils, and in 1924 formed their first government.[4] They did so on the basis of an even greater commitment to social reform than that exhibited by the Liberal party before the First World War. In response the renamed Unionist Reconstruction Committee became after the War the largest and most influential grouping within the parliamentary Conservative party. Chamberlain, by then, was one of its most prominent members, and indeed in 1925 became its chairman. The party leadership, however, remained cool on social reform. In February 1924 Chamberlain made note in his political diary of the feelings of the rank and file in the party "who were getting very impatient at our lack of a social programme".[5] When the party regained office under Stanley Baldwin in late 1924 Chamberlain recognised that the opportunity must be taken then to undertake Conservative social reform in order to maintain the party's electoral position and prevent Labour getting in again. In November 1924 he remarked in a letter to his sister that "unless we leave our mark as social reformers the country will take it out of us hereafter".[6] It is in this context that one should see Chamberlain's decision to take the office of Minister of Health in the Baldwin administration. Whilst not wishing to denigrate

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4. For the details of Labour successes in local government see J.S.Rowett, 'The Labour Party and Local Government: Theory and Practice in The Inter-War Years (unpublished D.Phil thesis, Oxford University, 1980), appendix.
5. Neville Chamberlain papers, NC 2/21, Political diary entry 6.2.1924.
6. Neville Chamberlain papers, NC 18/1/458, letter to Ida Chamberlain 1.11.1924.

entirely Chamberlain's personal commitment to social reform for the good of the people, he, nevertheless, to a large extent sacrificed the prestigious position of Chancellor of the Exchequer, for a position in which he felt he could secure social reform for the long-term electoral good of his party. It was clear, also that success in this sphere would considerably enhance his own political reputation.

Chamberlain was, therefore, as much a pragmatic politician who recognised his party in government should make the same positive reaction to general calls for social reform that the post-War coalition government had made, and on which basis the Ministry of Health had had to make policy throughout the early 1920s. In a similar way to Ministry officials, Conservative debate of social reform before 1924, in which Chamberlain took the main lead, was undertaken in an enclosed party environment, ensuring that policy could be developed that maintained principles of Conservative party philosophy. These included the preservation of the principle of self-help in all state provision, and provision made on an economical basis that did not place undue burdens on the taxpayer. Such principles were closely in accord with those adopted by civil servants, and so constituted the basis for a governing elite that went beyond the higher echelons of the bureaucracy. Such shared values and aims ensured that the policy options chosen for reform within the party, therefore, commonly branched off from existing government policy, which was imbued with those values and

aims. The full range of options for local government, central-local relations and social reform was not systematically investigated.

It is not surprising, therefore, to discover that Conservative reform policies had much in common with the policy options for incremental change, chosen within the Ministry of Health and the Treasury. One of the main proposals of the Unionist Social Reform Committee before the First World War was a reform of the poor law, in which it was suggested that guardian responsibilities should be passed to the county and county borough councils. In the administrative counties, however, whilst the county council was to be the overall responsible body, boards of guardians were to continue as committees of district councils. This was put forward as consistent with the Conservative principle for adaptation of existing systems of social policy, which were considered to uphold self-help, rather than provision for wholesale changes, which could have uncertain effects on Conservative aims in social policy.[7] Chamberlain, as a Conservative reformer, was made further aware of the potential of a poor law reform for the improvement of health care by his service on the Consultative Council on Local Health Administration in 1920. The integration and co-ordination of local health services in county and county borough councils offered a means of improving

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7. Unionist Social Reform Committee, Poor Law Reform. A Practical Programme (1912)

health care through greater efficiency rather than new and permanent state expenditure.[8]

Chamberlain's adoption of the poor law (health care) reform option for social reform in 1924 originated from this parallel consideration of reform. He also shared the Ministry of Health's aim to carry this reform without a reform of local government areas. He held a similar sympathy for county borough administration having been a former mayor of Birmingham himself. Whilst being perceived by many as a minister biased towards the activities of county boroughs he also developed a high regard for county councils. He noted in October 1926 after a trip to Devon County Council that "I am impressed by the activities of the county council. They are much better than I thought and quite capable of doing whatever is put upon them".[9] He considered county councils to be generally "competent" with the exception of Holland (Lincolnshire), which he thought ought to be amalgamated with Kesteven (Lincolnshire) as it "seems to have none of the gentry class and in consequence is poorly administered".[10] This judgment carried the implicit assumption that other county councils were "competent" precisely because they were governed by members of the county gentry, and, therefore, could be largely trusted

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8. PRO MH 57/137: minutes of the committee on health organisation and poor law reform. Report of the Consultative Council on Local Health Administration 4.9.1920.
9. Neville Chamberlain papers, NC 2/28, Ministry of Health provincial visits 1925-1927, Devon 13-15.10.1926.
10. Neville Chamberlain papers, NC 18/1/547, letter to Hilda Chamberlain 31.10.1926.

to conduct local government in terms of the same values and assumptions as central government. This largely bears out Crowther's analysis. Given the decision to conduct reform using existing institutions of local government, county and county borough councils presented themselves as the most politically reliable authorities to administer the poor law in line with the values of the bureaucratic elite and the Conservative party, ie to preserve a social policy designed to promote self-help against the forces of poplarism which threatened greater reliance on the state.

Chamberlain's approach to social reform using existing institutions · of local government was governed by imperatives similar to those which prejudiced the Ministry of Health's policy development. Other reform options were, consequently, not properly considered. Indeed, in private he acknowledged the limited nature of the poor law (health care) reform. In stark contrast to the rhetoric he used in introducing the poor law reform in the House of Commons in 1928, Chamberlain made an admission in a letter to his sister in 1925 of the small adjustment to existing policy which the poor law reform would make. He wrote of his discussions on poor law reform with Sir Aubrey Symonds "If we follow on present lines it will be rather a gradual progress than a drastic operating of present arrangements. In fact I think it would mean very little alteration in the country, the change operating more in the towns". Here he spoke with hopeful regard to the operation of out-relief more on

poor law principles, and the potential for hospital appropriation.[11]

Whilst no specific proposals for reform of the finance of local government were made within the Conservative party, Chamberlain easily adopted the block grant reform in 1924 also out of shared assumptions with central bureaucrats. He was as keen on minimising the cost to the taxpayer and ratepayer of social programmes as much as possible. For example, in a letter in October 1925 Lord Salisbury wrote to Chamberlain against percentage grants, "the bribe of half to be paid by government is alluring, dangerous and leads to damnation...[it] has produced a very high standard but it is death to economy. That I know is your conviction". Chamberlain was, therefore, a natural backer of Strohmenger's block grant for health services in order to control public expenditure.[12]

An indication of how much Chamberlain's promotion of poor law and block grant reform in late 1924 is to be seen in terms of shared motivations and approach to policy as his civil servants is given by the differences in treatment given by Ministry officials to Chamberlain and his predecessor, the Labour Minister of Health, John Wheatley. Chamberlain made his first consideration of reform when briefly Minister of Health in 1923. In September 1923 Sir Arthur Robinson urged his statistical

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11. Neville Chamberlain papers, NC 18/1/477, letter to Ida Chamberlain 14.3.1925.
12. Neville Chamberlain papers, NC 7/18/15, Salisbury to Chamberlain 24.10.1925.

officer to revise the figures for the block grant reform "as soon as possible".[13] There are, unfortunately, no more traceable records of policy discussions in 1923, but it is clear from the rapidity with which Chamberlain championed the programme for reform in late 1924 that he developed a very clear understanding of what he wished to do, and what his officials considered possible.

The urgent response to Chamberlain's attempt at consideration of reform in 1923 is to be contrasted with the dilatory response given to John Wheatley's attempt at reform in 1924. Wheatley took the view that unemployment had overloaded the capacity of boards of guardians to cope with the amount of assistance required. From a Labour point of view the most important thing was to reorganise the poor law as a whole to ensure that need was being met. This was a priority both in terms of the party's social philosophy and its electoral constituency. Duly, Wheatley went to Cabinet as early as March 1924, stating that he was "anxious to deal with this question as expeditiously as is possible in the circumstances". He continued, "I want to rescue my Department from an embarrassing situation and to pave the way for that reorganisation of the system of public assistance which is called for by members of all parties". In the absence of any considered party policy on local government reform, he advocated reform on the basis of the Maclean

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13. PRO HLG 68/26: Poor law reform. Organisation and functions of local authorities. Grants in aid of local authorities. Memorandum September 1923.

Report, but suggested that there should be an all party conference to debate the question.[14]

Such a conference was held in April but proved abortive due largely to the non co-operation of the other parties. However, discussions were held in the Ministry throughout the late spring and early summer. In August Wheatley reported to Cabinet that he and Ministry officials had "devoted much time and thought to the consideration of this question" and focused on four options. These were the Maclean proposals, proposals for the complete reorganisation of public assistance along the lines of the 1909 Minority Report. the reform of the London poor law only, and a poor law reform in London which formed a part of a larger reform of London local government as proposed by Labour MPs during the year. Under Labour, therefore, the consideration of local government reform and the reform of public assistance went wider than at any point since the end of the First World War. Perhaps as a result of Labour's desire to show themselves fit to govern, or as a result of persuasion by officials, Wheatley pressed the Cabinet to introduce reform on the basis of the Maclean option.[15] The Cabinet then consented to a Cabinet Committee, which a few days later agreed to Wheatley's proposals. Ministry of Health officials were duly instructed to draw up proposals for reform based upon the assumption of the abolition of the guardians and the transfer of their

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14. PRO Cab 23/CP 173(24), 17.3.1924.
15. PRO Cab 23/CP 429(24), 6.8.1924.

functions to other public authorities. Departmental papers on Ministry consideration from this point are no longer available, but one document shows that in August the Mond memorandum was pulled out and the figures updated from 1923.[16]

The important point to note is that this is the first evidence of Ministry officials providing Wheatley with the Ministry plan for reform. No previous steps had been taken to update figures voluntarily or cut out all other policy debate by immediately recommending the reform plan to Wheatley earlier in the year. They had waited upon Wheatley and supplied a detailed reform plan only when he had requested a reform plan based on the Maclean recommendations. This suggests that at best they were performing as neutral ciphers of their political master's wishes. If not, one could also argue that they took the view that the Labour Government was a minority one, whose days in power were numbered from the start. Consequently, it was not worth the sweat and toil of working on a reform which the Minister would not be able to implement. However, at the worst, it suggests that officials, suspicious of Labour's social philosophy, and worried by the alternative reform options put up by Wheatley during 1924 which were not in sympathy with their aims, were obstructive. They were unenthusiastic to have their reform proposals introduced by a Labour Minister for fear of an incompetent introduction or for

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16. PRO HLG 68/25. Update of the Mond memorandum, 8.8.1924.

fear of their development along lines contrary to their own wishes. The very real way in which senior civil servants in the Ministry had given Wheatley little active assistance in considering local government or social reform is shown by the fact that when Chamberlain came back to office late in the year, after brief consideration of the block grant reform, senior Ministry officials fairly fell upon Chamberlain with reform proposals based upon the Mond memorandum. Here was a Minister who the Ministry did feel they could trust.[17]

To suggest that he was merely welcomed by the Ministry of Health as one of their own would, however, omit the important additional motivations for poor law and exchequer grant reform that Chamberlain developed in the years after 1924. The point has already been made that Chamberlain perceived county and county borough councils as more reliable administrators of the poor law in line with central aims than the boards of guardians. The potential for poplarism could be significantly diminished and the attainment of out-relief on the principle of less eligibility significantly increased. However, from 1926 Chamberlain developed more explicit party political motives for a reform of the poor law. The rise of the Labour party to take control of a number of boards of guardians in the early 1920s was bad enough, but the Labour victories at the 1926 municipal elections convinced Chamberlain even more of the threat that the

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17. Neville Chamberlain papers, NC 18/1/460, letter to Ida Chamberlain, 12.11.1924.

rise of Labour at a local government level posed. In a letter to his sister, Ida, in November 1926, he wrote, "If it wakes us up now it will have been worthwhile for I see in the Labour attack a deliberate intention to seize local power to commit local bribery in one form or other; it can be done with tram fares or house rents or even gas and electricity charges as with out relief, and secondly they admit frankly that a Labour majority in the councils will create a more favourable atmosphere for carrying out the acts of a Labour government, an ominous suggestion in view of the way they behaved in some places during the general strike. More than ever I am disposed to think that I shall have to get powers to "west ham" local authorities".[18]

By the latter comment Chamberlain referred to the case where he had suspended an elected board of guardians for administering the poor law in a manner contrary to his wishes and replaced them with appointed nominees. These sentiments expressed with a reference to local government in general suggest Chamberlain's willingness to subvert local democracy in order to displace Labour from local bases of power so as to erode the potential for Labour success at a national level as well. From 1926 onwards Chamberlain's promotion of poor law reform was much more active. In this context reform may be seen specifically as a measure designed to concentrate local government in the county and county borough councils, where Labour had

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18. Neville Chamberlain papers, NC 18/1/548, letter to Ida Chamberlain, 6.11.1926.

had far fewer successes in the 1920s and had much less potential for success in the future. Such was his desire that he shrugged off calls for the disqualification of the pauper vote in poor law authorities, arguing that this would become superfluous once a poor law reform had been carried, for paupers were disqualified from county and county borough council elections.[19]

Chamberlain also developed party political reasons for the promotion of the block grant. He saw in it the potential for a cheap necessitous areas policy, where the necessitous areas could receive greater assistance but, except for the additional sum in the block grant, largely at the expense of richer authorities. This would meet the electoral need to be seen to be doing something about the problems of the depressed areas, without undermining the basic philosophy of the Baldwin Government to keep public expenditure on a tight reign. Such political reasoning meant that Chamberlain fought strenuously to preserve the intention to carry the block grant reform against all threats. For instance, in July 1926 the AMC sent a memo to Chamberlain which severely criticised the reform proposals and Sir Arthur Robinson "was for throwing overboard the block grant system at once". In the absence of continued bureaucratic will, Chamberlain's own reasoning in favour of a block grant kept it in the reform package and forced revision of the reforms to be

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19. Neville Chamberlain papers, NC 2/21, Political diary entry, 28.3.1926.

undertaken on that assumption.[20] In March 1927 he remarked bleakly on the Cabinet's decision then to allow him to consider reform only on the basis of poor law reform that "it leaves me without a necessitous areas policy".[21] His conviction to have one ensured that in the final compromise with Churchill in 1928 which achieved reform the block grant was part of the proposals put before Parliament.

Consequently, alternative motivations may be ascribed to Chamberlain's active promotion of the poor law (health care) and exchequer grant reforms which locate him as a member of a closed world of elite policy making and as an active proponent of social reform to stave off Labour electoral success at both a national and local level. It may also be seen that the reasons for his commitment to the reforms, especially in relation to exchequer grants, where bureaucratic enthusiasm waned, were more instrumental in gaining their achievement than some historians have previously allowed.

2. THE CREATION OF POLICY AND INTER-GOVERNMENTAL RELATIONS

Politicians obviously had considerable access to the making of policy in the central bureaucracy, and as well as stimulating the consideration of reform could shape

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20. Neville Chamberlain papers, NC 18/1/537, letter to Hilda Chamberlain 25.7.1926.
21. Neville Chamberlain papers, NC 18/1/566, letter to Ida Chamberlain 12.3.1927.

and influence its progress. Access given to other interests outside of the bureaucratic elite was distinctly more limited. Indeed in the period between 1918 and 1924 the Ministry of Health successfully insulated their reform consideration from all bodies which might suggest alternatives, such as the Meston Committee. Otherwise policy was made privately within the confines of the Ministry of Health. However, from the start Ministry officials were concerned about the views of those local authorities on whom they were dependent for the successful implementation of their proposed reforms, the county boroughs and county councils. This formed part of a new approach to including the local authority associations, which represented their interests, in the discussion of reform. The AMC council report for 1918 noted in relation to the 1918 Ministry of Health bill that "as a rule, when a Government bill is introduced nothing of a definite character is known of its provisions until after it has been read a first time and printed". On that occasion local authority association representatives were included in discussion of the bill long before it reached Parliament.[22] The development of formal relations after the First World War were accompanied by those of a more informal, but arguably no less important nature. A golf match between senior Ministry of Health officials and provincial town clerks, for example, was held annually

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22. AMC council minutes, 16.5.1919, p.116.

from 1923.[23] No access was given to local authority associations in relation to proposed reform of the poor law and exchequer grants immediately after the War but a precedent had been set with the Ministry of Health bill. Ministry officials were mindful of local authority opinion for the time when a bill would be in preparation and they would be given access. Reform had to be shaped with the interests of the local authorities in mind. To see how Ministry policy was shaped in the early 1920s, therefore, necessitates analysis of local authority association views.

With respect to such views it is important to note the structure of local authority association decision making. In the case of the CCA formal decision making powers were vested in its executive council, on which all county councils were represented. The executive council commonly established committees to consider particular issues, the committees' reports forming the basis for executive council debate. In the case of the AMC powers were again vested in a council, but representation thereon was more complicated. In 1919 it was decided that the five county boroughs with the largest population should as of right have representation on the council. After the 1921 census these were Birmingham, Leeds, Liverpool, Manchester and Sheffield. They retained privileged representation throughout the inter-war

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23. See, for example, Municipal Review (1936), p.196. The report reviewed the match position. After fourteen matches the score was 7-5 to the Ministry, with two years matches drawn.

period, as did the city of London. Beyond these, members competed for representation, a further thirty five places being reserved for county boroughs and forty places for non-county boroughs. The principal standing committee of the AMC was the law committee, on which the town clerks of the five biggest county boroughs again had a permanent place, the other places being up for election. They were also guaranteed representation on ad hoc committees established to consider individual issues, and on all committees and sub-committees they were allowed more votes than ordinary members. This was felt to be in accord with the greater funding of the AMC which the big five made. Despite moves for one member one vote during the inter-war years the structure of representation within the AMC created in 1919 persisted.[24]

(i) THE LOCAL AUTHORITIES, THE MACLEAN REPORT, AND POOR LAW (HEALTH CARE) REFORM BEFORE 1924

Local authority association discussion initially took place in the wake of the proposals of the majority and minority reports of the Royal Commission on the Poor Laws, published in 1909. The first off the mark with a considered response was the CCA. It is to the county councils that attention shall, therefore, first be turned.

In January 1911 the executive council of the CCA endorsed the report of the specially convened poor law

24. See AMC council minutes, 12.12.1919, pp.208-210.

committee, which had sat under the chairmanship of Arthur Chapman, member for Surrey County Council. This agreed with the general consensus of the 1909 reports that poor law administration should be reorganised as the present units of administration were often too small and because it was "very undesirable" to have more than one independently elected authority with rating powers in the area of an administrative county. It agreed also that the best authorities for supervision were the county and county borough councils. In the main the CCA then went on to agree with the Majority Report's advocacy of a transfer of the poor law with the principle of less eligibility intact. It concluded a plan that the county councils could administer the transferred services through a county poor law committee, which would determine policy on institutional relief, and determine and ensure relief rates, which were to be decided in individual cases by district poor law boards.

However, there were important riders to the CCA policy which had more in common with the desire to break up the poor law, first shown in the Minority Report and included in the later Maclean Report. Only here the CCA was stating the special preferences of county council feeling. First, they wanted all grades of mental deficiency taken out of the poor law and placed with the other responsibilities of the county councils lunatic asylums committees. They then wanted all direct responsibility for mental deficiency and lunacy taken away from county councils and given to a central

government department instead, leaving local committees the power only of inspection. This was an important early indication of local authority antipathy to this sort of health care work. No other specific provisions were made for transferred health services, but the relief of unemployment and education were also singled out. In the former case it was again the feeling that direct responsibility should rest with central government with the local authority only helping out in temporary cases. This was again a clear indication that the counties had no desire to administer a heavily burdened system of poor relief. For poor law schools unification with others under the jurisdiction of the education committee was felt to be the best way forward.[25]

The CCA position on poor law reorganisation in 1911 undoubtedly provided some encouragement to the later Maclean Committee. The county councils were apparently prepared in principle to take the poor law, although had some preferences towards breaking it up. However, the response to the Maclean Report in 1919-1920 revealed deeper concerns amongst the county councils than previously shown. In 1919 the reconstituted poor law committee of the CCA, again under the chairmanship of Chapman, requested the feelings of all county councils. In November 1919 the committee reported to the executive council the fact that on the whole the county councils were very unenthusiastic about reform. Of fifty-nine

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25. CCA circular to county councils, vol III-IV (1910-1911), pp.18-20. Report of special meeting of CCA executive council 24.1.1911.

councils nineteen had not bothered to supply information at all. A breakdown of the reaction to the Maclean Report of the remaining forty may be seen below:-

(1) No Definite Opinion: Eight

Berks, Bucks, Cornwall, Lincs (Kesteven), Soke of Peterborough, Somerset, East and West Suffolk.

(However, East Suffolk did state "the view that county councils have at present as much work as they can undertake", and in Kesteven and Somerset the council was evenly divided over the desirability of the abolition of the guardians).

(2) Acceptance: Nine

Breconshire, Carmarthenshire, Denbighshire, Derbyshire, Durham, Flintshire, Middlesex, Notts and Surrey.

(Both Breconshire and Middlesex stipulated certain conditions).

(3) Partial Acceptance: Thirteen

Bedfordshire, Cheshire, Cumberland, Derbyshire, Gloucestershire, Hants, Isle of Ely, Lancashire, Lincs (Lindsey), Northants, Warwickshire, and the East and West Ridings.

These councils either preferred existing accommodation or did not accept some of the Maclean Report proposals. They stated which of the existing and transferred duties they were prepared to fulfill. These were:-

Institutional care of sick	6
Domiciliary care of the sick	4
Care of m.d.'s and lunatics	10
Care of the aged	2
Non-med home assistance	1
Education and child maintenance	9
Vagrancy and unemployed	2
Assessment	5

(In addition Bedfordshire was willing to supervise public health, and Derbyshire administer work under the Vaccination Acts and the registration of births and deaths. Several authorities had different suggestions on assessment. Only three answered the question on co-option: Cheshire was against and Hampshire and Northamptonshire were both of the opinion that increased facility to co-opt was a good thing).

(4) Total Objection: Ten

Devon, Dorset, Herefordshire, Hunts, Isle of Wight, Kent, Norfolk, Sussex (East), Westmoreland and Worcestershire.

The facts and figures reveal that there was very little unqualified support for the Maclean Report proposals. Apart from the indifference of those who did not reply, which can be interpreted in a number of ways, and the hedged antipathy of those who declined to give a firm opinion, it is clear that there was root and branch opposition from at least 1/6 of county councils and sizeable opposition from another 1/6. In particular,

responsibility for home assistance, care of the aged, and vagrants and the unemployed was very unpopular, with that of institutional and domiciliary care of the sick not being greatly less so.

The members of the CCA poor law committee, nevertheless, were inclined towards acceptance of the majority of the Maclean Report and, despite the manifest opposition from many councils, made recommendation to the executive council to that effect at the November meeting. Moreover, the committee drew particular attention to their opinion that "wide areas are essential for the efficient and economical administration of institutions", thus giving the strongest possible support to the transfer of poor law health services and their subsequent unification with county services. The one area where a priori agreement existed against the Maclean Report was on training and the prevention of unemployment. This was duly voiced again. However, the added strength of feeling against assuming responsibility for home assistance could not be ignored either. Consequently, the committee recommended that home assistance provision by the county councils "would not be economical" and "should therefore be carried out within the administrative county areas by responsible minor authorities". Moreover, the latter would be financially responsible for the entire cost of home assistance duties.[26]

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26. CCA Official Gazette (January 1920), pp.9-10. Reports of CCA executive council meetings, 16.10.1919 and 12.11.1919.

It is clear that both the recommendation of acceptance of the bulk of the Maclean Report and the rider on home assistance were highly controversial at the November meeting. Chapman, Sir Ryland Adkins and Henry Willink led a heated debate of the poor law committee report which proved inconclusive, and the executive council resolved to postpone decision until the government made their next step. However, at the annual general meeting of the CCA in March 1920 the issue was brought back on to the agenda by Henry Willink. In the ensuing discussion the division of opinion became clear. Willink himself shared others' concern at the "relaxation" in the implementation of the poor law, which had led to heavy increases in public expenditure over the last few decades with no discernible decline in the numbers receiving public benefits. He felt that "at such a time as the present, with this habit of large expenditure warping us all" any reform that may lead to even greater expenditure and further weaken the stimulus towards independence and efficiency was irresponsible. Considering that the Maclean proposals actually intended to transfer a large part of the poor law in to a part of public provision that was intended to be popular he felt that such increases in expenditure and erosion of individual self sufficiency should not simply be feared but expected as a consequence of these proposals.

He then addressed the specific question of health reorganisation. He accepted the need for consolidation of local bodies in principle, but in practice felt it

essential that the poor law remained unified. Its break up would, moreover, lead to far worse inefficiencies. First, people in the same family may well get categorised in different classes, leading to overlapping of provision from different committees. Secondly, he felt that the cost of moving people around the county from existing mixed institutions to specialist institutions would be high. However, most importantly with regard to poor relief, he felt that a chain of command that went from district committee to county home assistance and finance committees before reaching full council would not only involve great expense but also tend to over-bureaucratic administration. Moreover, to have a strong county council would tend to erode the initiative of local officials, and similarly, to have strong district committees would erode the aim of theoretical unity in county council administration. His essential point was that to make reorganisation of home assistance workable in practice would inevitably mean the loss of some of the advantages which had been stated in its defence.

Willink, of course, had easy recourse to support. The November report, he said, "certainly does not indicate any enthusiastic readiness on the part of county councils to approve the proposals". He then went on to give his own explanation. "The fact is that most councils feel that they already have quite as much to do as they can manage; and it is probable that feeling, even more than reasoned objections, weighs with many persons." Consequently, he voiced the argument against reform on

the grounds of county council expressed interests. Further, he re-iterated the common view that the poor law should be a "properly unified system administered on the sound principles of 1834" and if it were to be broken up he argued that it "cannot tend to economy of expenditure, to greater efficiency of administration or to the general good." Weighing heaviest in favour of his arguments against any sort of reform was the widespread antipathy in county council government to the assumption of responsibility for poor out-relief, or home assistance as it was to be called.

Willink was opposed forcibly again by Sir Arthur Chapman, who was determined to get the CCA to accept the Maclean Report in principle. Because of a lack of sources his full reasons remain unclear, but although he was equally concerned at the possibility of any additional expenditure he was persuaded of the logic of the Maclean proposals. He felt the county councils could and should administer the transferred services, in particular the health services. In this he was voicing the opinion of his own council, Surrey, who had supported the Maclean proposals in November. It is clear that Chapman was a respected major figure on the executive council and his opinion carried weight, but he was concerned to get a compromise that would please more members. As a result he again proposed the motion that home assistance and employment not be taken on, and should instead become the financial and administrative responsibility of borough, urban and rural district

councils, reports of course still being made to the county council. After a lengthy debate acceptance of the Maclean Report with this amendment was resolved and duly published.[27]

As a result, by the spring of 1920 the Ministry of Health was made well aware of the fact that although the bulk of the Maclean Report was officially accepted by the CCA, they faced outright official opposition on the question of receiving home assistance duties as recommended by Maclean. In addition, with many county council figures moving in government circles, it was not hidden to officials that behind the official acceptance of the bulk of the Maclean Report lay a lot of opposition that also had to be overcome if reform was to be made practicable in the counties.

The reaction of the AMC, representing county borough and non-county borough feeling, was also problematical. Due warning of opposition against any erosion of powers was given by the secretary of the AMC, Harry Pritchard, who as a member of the Maclean Committee had signed the eventual report but added a significant accompanying memorandum. In the memorandum he opposed two ideas in the report which he felt undermined county borough council autonomy: first, that of co-option; and secondly, that of obliging the recipient authority to create a home assistance committee. With regard to the former, he saw it as a basic right of a democratically elected body to

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27. CCA Official Gazette (April 1920), pp.56-64. Ad verbatim report of the CCA annual general meeting, 24.3.1920.

determine the personnel of its committees itself. The compulsion of co-option took away that right. With regard to the latter, again he saw it as the right of elected local authorities to organise its work as they saw fit. If they faced compulsion, he felt that "not only will unnecessary difficulties be placed in the way of councils in the performance of onerous duties, but there is the real fear that the new statutory committees, and particularly the home assistance committees, will be regarded as the old poor law authority under a new name."

More importantly, Pritchard also served notice of the AMC's support for the non-county boroughs against the proposal to transfer all guardian health services in the administrative counties to the county councils. He admitted that in the majority of cases institutions were best administered by the county council so as to be available for the whole area. But in some cases this would not be true. In particular, infirmaries would be most efficiently utilised if they were transferred to the town council where in use. Moreover, "as regards medical assistance" he wrote "I entirely dissent from the proposal that this should be given by the staff of the county medical officer of health, except in the cases of certain boroughs and urban districts, which are apparently to be regarded as exceptional". Many borough and district councils had been executive health authorities for many years, and generally speaking their administration had been at least satisfactory.

In conclusion, he was "convinced that the proposal to have two health authorities, viz., the county council and the borough and district council, both administering the Public Health Acts and both dealing to a large extent with the same persons would lead to much friction and dissatisfaction and to unnecessary expenditure". He ended, therefore, by arguing against the detail of the proposed transfer of guardian functions on the grounds of the Maclean argument itself. Generally, efficiency and economy in the new unified services in the counties would not be best attained under the Maclean proposals but by the framing of individual schemes within each administrative county by the county council in conjunction with minor authorities.[28]

In 1918 the AMC council initiated further consideration of the report by the law committee, under the chairmanship of Sir Robert Fox, town clerk for Leeds. This duly reported its recommendations in January 1919. In contrast to the CCA, the committee assumed the abolition of the boards of guardians and did not consider the premises for reform worthy of further debate. This is perhaps indicative of the fact that at this time the AMC had few hopes of actually being able to initiate or reject legislation. Their role was simply to gain incremental successes by virtue of the debating of details. Neither did they consider it worthwhile to ballot the members of the AMC on their individual

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28. Report of the Maclean Committee (cmd.8917), PP (1918), accompanying memorandum.

reactions to the Maclean Report. Instead AMC policy was made totally in the context of council members on the recommendations of certain senior figures who manned the law committee.

The committee's report totally endorsed Pritchard's criticisms. The issues of compulsory new committees and co-option with nomination by outside bodies were both discussed with grave concern. A close reading of the Maclean Report had further revealed that the proposed new home assistance committee, as well as the proposed employment committee, on county borough councils would have statutory duties and executive powers invested in it by legislation. Other committees of council were given executive powers by the council. As a result, councils were able to guide the policies of different committees in conjunction with one another. If the H.A.C. were to be vested with powers by outside bodies it would become largely an independent authority, simply administering over larger areas than previous boards of guardians which would make council finance and the co-ordination of policies very difficult. Co- option with nomination by outside bodies they felt simply to be a " return to the exploded idea of representation of interests with its undesirable implications, and is a direct blow at the democratic constitution of the council and their responsibility to the whole body of citizens." Particular concern was voiced at the effect of the proposals on the larger non-county boroughs, who had the most responsibilities for health provision. The

committee concluded "that the proposed transfer to county councils would cause the utmost confusion, with endless duplication of effort and resultant expense in boroughs of this class." Consequently, the committee specifically recommended that transferred guardian health services where appropriate should be allocated to these larger boroughs.[29]

The law committee report was adopted in full by the AMC council and was to remain official policy until 1925. As with the CCA, Ministry of Health officials in 1920 could comfort themselves with the fact that the AMC had accepted the Maclean Report, but again there was opposition on important elements of the proposals. In particular, to the problem of county council opposition over assuming responsibility for home assistance there was now added the problem of AMC dissent over the apportionment of health responsibilities in the administrative counties, upon which as has been shown above there was some CCA sympathy. Clearly, the reform of the poor law and the reorganisation of health care in the administrative counties along the lines of the Maclean Report faced major stumbling blocks in the local government world. Devising proposals that would also win consent from the bodies responsible for their implementation, who were now gravely suspicious, was one of the major tasks facing the Ministry of Health internal committee in late 1920.

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29. AMC council minutes, 23.1.1919, pp.42-53.

(ii) THE LOCAL AUTHORITIES AND FINANCIAL CENTRAL-LOCAL RELATIONS REFORM BEFORE 1924

Local government pressure for the reform of exchequer grants dated well back before the First World War. The first priority had always been that of larger grants rather than changes in their nature. The desire for grants to be related more to needs was important but generally secondary. The basic problem was that local government had taken a large share of the growth in state intervention since the late 19th century. Local authorities felt that for many of the services that were deemed by both the 1901 and 1914 Reports to be of national importance they received too little national exchequer grant aid. This placed too great a strain on local sources of revenue, especially in high areas of service need which, as has already been noted, were generally the poorest.

Consequently, in evidence to the Kempe Committee, both the CCA and the AMC had advocated large increases in several exchequer grants.[30] When Lloyd George's 1914 budget contained proposals that met these hopes, within a reorganisation of the basis of central finance, they were highly delighted. On the cessation of war it was to this eve of war plan that attention again quickly turned. However, the AMC alone took the initiative as many of its members were faced with even greater financial burdens

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30. Report of the Departmental (Kempe) Committee on Local Taxation (cmd. 7315), PP (1914), paras 28-32.

after the war. At the behest of Leicester county borough council, in June 1919, the association decided to press the government to reintroduce the proposals without delay.[31]

There followed a steady stream of parliamentary questions throughout 1919 to both Addison and Austen Chamberlain, which continued in to 1920. The predominant themes were the demands for more money and the distribution of grants on a more equitable basis. The ministerial answers all assured the questioners of their hopeful intent to meet these demands but answered that no definite plans could be laid before Parliament at the current time. By November 1920, with no government proposals for reform forthcoming, individual county boroughs were producing their own plans. Some suggested that local authorities were experiencing grave financial problems. Chester county borough proposed "that the cost of national services administered locally should be paid for out of national funds" and not draw in any way upon the local rate. Others suggested that the position of subjugation with respect to the minutiae of central control added insult to the injury of starved funding. Worcester county borough, for instance, proposed the abolition of all government grants and suggested instead that "every local authority shall be entitled to receive from the government an agreed proportion of its annual expenditure, and to apply the same in aid of the amount raised locally, in such a manner as the local authority

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31. AMC council minutes, 19.6.1919, p.185.

thinks fit, within the powers by law conferred on the authority."[32] Other proposals for reform took a more global view of the problems facing local government. Lowestoft and Harrogate councils framed a joint motion to the AMC council which argued that such problems "are mainly caused by the unsound financial and constitutional system on which the Local Government Act, 1888, is based." They called for nothing less than a complete reform of local government.[33]

None of these proposals, however, became official AMC policy. The majority of members of the AMC council were too well aware of the economy constraints on central government. In the CCA this was even more the case. Indeed the only post-war CCA demand for greater central funding came with just such a recognition of central problems.[34] This is not to say, however, that the local authority associations did not give some clear indication to the Ministry of Health of what long-term grant system they wished to see. The AMC again took the main initiative. In 1919 the AMC council instructed its law committee to undertake an in-depth study of local health administration. This produced important confirmation of the majority view on what was the best form of central-local relations. With regard to financial relations, in the short-term, the accumulation of percentage grants for different branches of the health services was found to be

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32. AMC council minutes, 18.11.1920, p.75.
33. AMC council minutes, 11.3.1920, p.17.
34. CCA Official Gazette (April 1920), p.85. Report of CCA executive council meeting, 10.3.1920.

very beneficial, but the report expressed the hope that they "might possibly be superseded by a general block grant when public opinion had been sufficiently educated." Similarly, in the long-term the report advocated that central administrative control be along the lines of paragraph 69 of the 1914 Report, which gave local authorities freedom from detailed expenditure control and therefore greater local autonomy. This was completely consistent with the framework for central-local relations associated with a block grant. The whole of the report, including these recommendations, was duly ratified by council.[35]

By contrast, there was no clear county council position on exchequer grant reform until November 1922. Indeed, the CCA did not begin an exhaustive examination of grants until March 1921, when a special exchequer grants committee was set up under Sir Arthur Chapman consequent on a paper read by him at the annual general meeting.[36] The report found in favour of the creation of a block grant system. However, certain qualifications were stipulated. First, no local authority was to lose grant income through reform. Secondly, the committee feared that the grant could become unfavourably disproportionate to the cost of provision to the local authority if it were fixed for too long a period. Therefore, they recommended that the vote for a block grant period be no longer than three years. Further,

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35. AMC council minutes, 19.6.1919, p.157-167.
36. CCA Official Gazette (April 1921). Report of CCA executive council meeting, March 1921.

they recommended that no additional responsibilities be placed upon local authorities during the period covered by the vote unless additional central funding was provided. Fourthly, they required that re-examination of the working of a new grant scheme should come at the earliest possible time. The principal qualification imposed, however, was the demand for "a definite guarantee that the meticulous supervision of detail by government departments which has hitherto prevailed shall cease."[37]

The CCA committee's views were becoming known towards the end of Ministry deliberations in the preparation of the Mond memorandum in May 1921. One can reasonably speculate, then, that Ministry officials through professional contacts were amongst those who believed that the post-war county council position was more or less consistent with pre-war support for a block grant and greater local autonomy. Thus, senior Ministry officials perceived both county borough and county councils as being in favour of reforms realisable through a block grant. It is in this context that one may see the decision to include a block grant reform in the Mond memorandum as an offsetting inducement to local authorities to accept poor law reform, which, as shown above, Ministry officials already knew to be unpopular. The inter-related reform plan rested on the assumption of

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37. CCA Official Gazette (November 1922). Report of CCA executive council meeting, November 1922.

the universal popularity of the block grant principle in local government.

However, in November 1922, when the special committee's report was finally debated by the CCA executive council, only the suggestion that the meticulous supervision of detail by government departments should be abandoned enjoyed wide agreement. At an acrimonious meeting it was resolved that the percentage grant system, with this proviso, was to be preferred to the committee's advocacy of a block grant.[38] The Ministry's assumptions of local authority views on exchequer grants were further undermined by evidence given to the Meston Committee in late 1922. The AMC and the Institute of Municipal Treasurers as expected were in favour of a system of fixed grants for public health services for periods of up to five years. The representative for both, Arthur Collins, felt that such a system would give elasticity, make grant reflect need and facilitate a proper comparison of local authority performance, allowing the Ministry to judge whether high spending local authorities were in fact inefficient. Collins added further that "it may be possible that the gradual levelling down of the expenditure of high spending authorities and levelling up of the standard of performance of backward authorities might pave the way for the adoption of some sort of national standard of performance, and some sort of uniform grant per unit such as that suggested in the Ministry's original scheme".

38. ibid

The split in county council opinion, however, was fully revealed to the Meston Committee. Six county councils, represented by Sir Arthur Chapman, had passed resolutions in favour of fixed grants to be revised annually. Yet, Mosse, the secretary to the Committee, reported that "the majority of the county councils and the urban and rural district councils are opposed to fixed grants". Their objection was based upon fears that meticulous control would not in fact be dispensed with, that they would be pressed to incur additional expenditure during the fixed period, which would fall on the rates, and "that progress would be checked, or progressive authorities penalised".[39]

Mosse's own view was that the county council opposition to block grants was not serious nor based upon rational argument. Rather, it reflected "a sort of hereditary repugnance to fixed grants which may be traced to experience of the assigned revenues system, and to an imperfect understanding of the alternative systems proposed".[40] Yet, it provides an important context for understanding why Sir Arthur Robinson's support for a block grant began to subside in 1923. If it was not to be a means of gaining local authority support for poor law reform and indeed would be actively opposed by them, then there was little argument for its continued inclusion in the Ministry's plans for reform. It would appear logical to suggest that it was as a result of this

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39. PRO HLG 52/342, Mosse to Strohmenger and Robinson 4.1.1923.
40. ibid

that the grant question remained open within the Ministry in 1923 and 1924, only to be concluded by Strohmenger's strong argument in favour of sticking to a block grant reform in late 1924. It provides further explanatory evidence of why Robinson was so quick to urge the abandonment of the block grant reform when the AMC also started to argue against it in 1926.

It is apparent that the power of local authority opinion over senior Ministry of Health officials was indeed substantial, helping to stimulate both the advance towards and near retreat from the advocacy of a block grant reform. The block grant in both 1924 and again in 1926 was only kept on the blocks by influences within central government from outside the Ministry of Health, namely, the Treasury's influence through Strohmenger, and Neville Chamberlain's own political imperative for a cheap necessitous areas policy. This did mean, however, that in the open debate with the local authority associations after the publication of the reform proposals in 1925, senior Ministry officials could look forward to what Robinson succinctly described as a "struggle" both in relation to poor law and exchequer grant reform.[41]

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41. PRO HLG 8/81: Royal Commission on Local Government- constitution, functions and relations of local authorities, and its work in regard to provisional proposals for poor law reform. Sir Arthur Robinson to Neville Chamberlain, 19.3.1926.

3. THE REVISION OF REFORM AND INTER-GOVERNMENTAL RELATIONS

The reform proposals published in 1925 were based on the Mond memorandum of 1921. At their core lay the intention to transfer poor law responsibilities wholesale to the county and county borough councils. In the counties, county councils would be allowed considerable discretion over delegation of responsibilities to second tier authorities but would retain overall financial and administrative control. In addition the county councils were be to given general supervisory and controlling powers over second tier authorities with respect to the latter's existing public health responsibilities. No indication was given, however, as to the intentions with regard to co-option on to county or county borough committees responsible for implementing the reforms. The intention to introduce a block grant along the lines indicated in the Mond memorandum was announced, the formula for distribution remaining solely based upon population and assessable value. No mention was made of any additional sum to be included in the grant. The proposals were more in the nature of a general summary of intent than a detailed elaboration of what bill clauses may be.[42]

The Ministry of Health's approach to the promotion of these proposals had much in common with that of the

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42. ibid, copy of provisional proposals for poor law reform, 1925.

immediate post-war period. Senior officials were anxious to insulate their proposals from further debate. Within government they were ably protected by Chamberlain, who refused to allow the Barstow Committee, or the Cabinet Committee, set up in 1928 as a result of Churchill's derating initiative, to reopen discussion of essential principles of reform. Whitehall policy makers also remained aloof from the observations of local government academics and the Labour Party, which as Rowett has shown, did not in any case have a systematic local government policy of its own to promote.[43] However, once the Ministry's reform proposals were published in 1925 they were considerably more vulnerable to attacks from beyond Whitehall.

Indeed, just as the Ministry's limited reforms were crucially promoted by the political imperative for reform in the person of Neville Chamberlain, they also faced after 1925 political forces against change of any kind. In sharp contrast to the fortunes of internal Ministry forces against change in relation to exchequer grants, which continued to express their views unsuccessfully in the late 1920s, these political forces had considerable power.[44] It has already been well described by a number of historians how rural guardians opposed poor law reform, and their support from Conservative backbenchers

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43. Rowett, thesis.
44. For evidence of continued support within the Ministry of Health for percentage grants in relation to local health services see, for example, PRO HLG 29/262: Papers and correspondence relating to various draft bills on poor law reform 1918-1927. Sir F.J.Willis to Robinson, 9.6.1926.

threatened to derail reform altogether, but it would be entirely wrong to characterise the concessions made by Chamberlain in 1927 and included in the 1929 Act in order to stave off this opposition as meaningful but not threatening to the principles of the reform. Moore has shown convincingly how the concessions with respect to co-opted representation on public assistance committees, the statutory requirement of guardians committees in administrative counties, co-opted representation on guardians committees and the maintenance of domiciliary medical relief by guardians committees served to undermine the aim of unity in local health administration. For they ensured that former guardians would have a key role in administration after reform, allowing them the facility to prevent the appropriation of poor law services under public health acts, a phenomenon of the 1930s described by Abel-Smith. The concession in respect of domiciliary relief mitigated against having all poor law medical services concentrated at a county level.[45] Thus the exercise of forces within the political elite against change meant that the poor law (health care) reform was in part at least inherently flawed.

Ministry officials also had to deal with the potential intervention of the Royal Commission on Local Government, chaired by Lord Onslow, which by early 1926 was looking towards the second part of its inquiry in to the

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45. S.Moore, 'Conservative Party Opposition to Neville Chamberlain's Social reforms, 1925-1929' (unpublished MA thesis, Birmingham University, 1984), p.184-201

structure, areas and internal organisation of local government. In this respect the Ministry was more successful in insulating the reforms from external influences. In February 1926 Onslow wrote to Chamberlain, offering the Royal Commission as a mediator in the discussions over the poor law and block grant proposals.[46] Robinson advised Chamberlain against accepting a role for the Royal Commission in both January and March 1926, suggesting that the proposals represented a significant reform "and the handling of it can only be by you".[47] Chamberlain concurred, and on Robinson's advice, directed the Royal Commission, in their inquiry into local government structure and areas, towards the issue of second tier authorities rather than that of county and county boroughs, whose continued existence was a given assumption of the 1925 proposals. This ensured that the Ministry's proposals would not be rediscussed or influenced by the many varied interests and opinions represented on the Royal Commission.[48]

It is apparent that Onslow also backed off from pushing for a Royal Commission role. In February it was reported to Robinson that Onslow had withdrawn his offer as a "result of a conversation with Sir E. Turton, who would, he gathers, support, the suggestion, and may put it forward as an inspiration of his own, as one more means of obstructing the reform proposals".[49] Turton, an

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46. PRO HLG 8/81, Onslow to Chamberlain, 12.2.1926.
47. ibid, Robinson to Chamberlain, 19.3.1926.
48. ibid, Robinson to Chamberlain, 4.6.1926.
49. ibid, Heseltine to Robinson, 25.2.1926.

M.P and a member of the Royal Commission, was also a senior member of the CCA Executive Council. New consideration by the Royal Commission had obviously been targeted by the CCA as an ideal delaying tactic which could help to kill reform. This episode was symptomatic of the fact that the key focus for the development of the reforms lay in the relations between the Ministry and the local authority associations. To this battleground the revision of the reforms was otherwise effectively limited. Conflict arose both in relation to poor law (health care) and exchequer grant reform.

(i) THE LOCAL AUTHORITIES AND POOR LAW (HEALTH CARE) REFORM, 1925-1929

In March 1920 the CCA executive council had been the scene of considerable dispute over the proposals contained in the Maclean Report, and had only confirmed its acceptance of poor law reform on the basis of home assistance becoming a second tier responsibility. Even then county councils had expressed their varied reluctance to the taking over of certain transferred poor law health services. In response to the publication of Ministry of Health proposals the CCA appointed a special poor law committee in October 1925, again under Sir Arthur Chapman, to reconsider the position. The committee suggested an enthusiastic response. Its members happily supported the idea of county councils having a supervisory and controlling role over second

tier authorities in the provision of health services, and of assuming responsibility for all transferred services. In this latter respect, they suggested that county councils had become altogether more modern and prominent in county government since the War. Further, they accepted that public assistance and health services were better co-ordinated over a larger area of cost. The Ministry's proposals further allowed county councils to delegate both health and public assistance responsibilities to second tier authorities, thus enabling county councils the discretion to make their own arrangements for administration. Such arguments echoed the approach promoted by Chapman in 1920. In February 1926, in sharp contrast to this previous bruising encounter, the executive council endorsed the approach.[50]

It is perhaps not surprising that on this part of the reforms, at least, the Ministry from the start received a favourable hearing from the CCA. For with regard to the administrative counties it considerably enhanced the status of county councils. In particular the concept of the county council as supervisor and controller on behalf of central government was too attractive to allow a carping response to the Ministry's proposals. The CCA's general endorsement of the administrative reform remained constant thereafter. Nor is it surprising then that what appealed to the CCA met with considerable hostility from the AMC. County boroughs generally accepted the transfer

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50. CCA Official Gazette (March 1926), pp.78-83. Report of CCA executive council meeting, 17.2.1926.

of poor law services in their areas to their jurisdiction, and the members of the AMC as a whole were content that the 1925 proposals had dropped the idea of co-option. However, the AMC also represented the non-county boroughs, who solidly opposed the Ministry's proposals for reform in the administrative counties. In November 1925 the AMC Council recorded its displeasure that all poor law health services should be transferred to the county councils, with delegation left to their discretion. Non-county boroughs had a long history in the public health field, and it was considered that at least those non-county boroughs which were elementary education and maternity and child welfare authorities should as of right receive poor law health services in their areas. The Council also considered that the proposal for general county council control over the health services was "open to the gravest objection". County council powers had previously been restricted to the receipt of medical officer reports and some default powers. What was suggested now appeared to strike at the very independence of non-county boroughs, and aroused enormous confusion and uncertainty on their part.[51]

For their part senior Ministry officials expected a bad reaction from non-county boroughs. The Maclean Report had left the door open to the larger non-county boroughs becoming poor law authorities. The Ministry's proposals in 1925 soundly slammed it shut, and made the addition of the county council's supervisory and

51. AMC Council minutes, 26.11.1925, p.243.

controlling role, which had not been at all expected by local government. The principal aims of the proposals were to ensure that health administration was unified over the largest area of charge and to promote county councils as the means of monitoring second tier provision, particularly with regard to the smaller districts. It was not envisaged that county council control would really have any relevance to the larger second tier authorities.[52] Yet, officials were not prepared to compromise with the essential principle of the strong county council. Rather, they approached the issue from the perspective of really wanting to make the role of the county council even stronger. In March 1926 Francis remarked in an internal memorandum that "it was unfortunately inevitable that county boroughs should become poor law hospital authorities, but the mischief and crippling of the county administration would be substantially increased by the enlarged concession to the non county borough".[53] Hence, Ministry officials looked to make as little compromise with the interests of non-county boroughs as possible.

From December 1925 in letters to Harry Pritchard, the secretary to the AMC, Robinson consistently rejected further AMC arguments that non-county boroughs should

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52. See, for example, PRO MH 57/138: Poor law reform proposals-reactions of AMC and Ministry of Health-AMC dealings-November 1925-December 1926. Minute of meeting between Neville Chamberlain, Ministry of Health officials and AMC deputation 21.7.1926.
53. PRO HLG 29/262: Papers and correspondence relating to various draft bills on poor law reform, 1918-1927. Memorandum by H.Francis, 5.3.1926.

become poor law authorities, and clarified the extent of county council control envisaged. It was intended that it should cover second tier authority health services, both grant aided and not. This would include the power to apportion and withhold grant out of the block grant to maternity and child welfare authorities, a more general power for county councils to make representation to the Minister in regard to defaulting authorities, and a statutory responsibility for the Minister to act upon representations. This could lead to three possible outcomes: complete transfer of cost and administration of a second tier authority service to the county council; a temporary transfer; or the transfer of administrative responsibility to the county council with cost remaining with the second tier authority. With respect, in particular, to the idea of the county council having power over grant apportionment to second tier authorities it is clear that Robinson was bringing in by the back door an important power which had originally been rejected in Ministry of Health discussion in 1920.[54]

The AMC reacted angrily. A deputation to Robinson in March 1926, led by the Lord Mayor of Birmingham, argued bitterly against the enlargement of county council powers, claiming that it was clearly ridiculous that county councils should have large powers over such non-county boroughs as Luton, Bedford and Cambridge, which had populations comparable with some county boroughs. It

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54. PRO MH 57/138, Robinson to Pritchard 15.12.1925 and 21.4.1926.

might not be the intention of the proposals to allow county councils to interfere with such authorities, but their wording allowed for that possibility.[55] In June 1926 the AMC council adopted the report of a special committee, which suggested that the Ministry had acted poorly in defining what county council powers should be when such a matter should properly have been left to the Royal Commission, and questioned the ability of county councils to exercise such powers when they had little or no direct experience of such services as water supply, sewerage and refuse disposal. The report concluded that the adoption of the proposals "would tend to introduce resentment and bitterness in the relations between the two classes of local authorities". If powers over non-county boroughs were to be increased at all they should be with respect to the Ministry and not county councils.[56]

The expression of urban authority resentment reached a climax at an AMC meeting with Neville Chamberlain in July 1926. After a cautious and reasoned speech by Harry Pritchard Alderman Wright of Lancaster roundly condemned the proposals and ended by saying that " we only want you to know that throughout England the non-county boroughs are up in arms on this question". Chamberlain robustly defended the aim to have only county councils as poor law authorities in county areas, as they covered the greatest area of charge. With regard to county council-second

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55. ibid, minute of AMC deputation, 24.3.1926.
56. AMC council minutes, 30.6.1926, p.169.

tier relations Chamberlain remonstrated that the proposals had been misinterpreted. "All we had in mind", he said, " was to strengthen up those [existing county council] powers and make them effective where they have up to the present proved ineffective". He did not envisage detailed county council control, and concluded that the non-county boroughs had over-reacted. In replying in this way Chamberlain, however, failed to appreciate the very real way in which the proposals represented another victory for county against town in the assumption of public responsibilities, and the tendency within the Ministry to promote the powers of county against town in the responsibilities which they already assumed.[57]

The confrontational approach taken by the AMC deputation in the July meeting, nevertheless, provoked a spirit of limited compromise on the part of Chamberlain and senior officials. They held smaller meetings with AMC representatives in the late summer of 1926 and promised to reconsider the proposals.[58] This resulted in circular 805, issued to local authorities in June 1927. This maintained the principle of transfer of poor law services to county councils in the administrative counties but allowed for delegation to second tier authorities. Essentially, the proposals in this respect

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57. PRO MH 57/138, minute of meeting between Neville Chamberlain, Ministry of Health officials and AMC deputation 21.7.1926.
58. ibid, for example, meeting between Neville Chamberlain, Ministry of Health officials and AMC representatives 29.7.1926.

remained unchanged from 1925, and were to remain so in to the 1929 Act. Moreover, the powers of county councils over second tier authorities were more rigidly defined. A communication from the Ministry of Health in November 1926 had signalled the end to the attempt to term the county council as the general supervisory and controlling authority for county areas. Existing county council powers were merely given more effect in law, and applied only to the statutory duties of second tier authorities. In addition, by November 1926 the Ministry had agreed that the apportionment for second tier maternity and child welfare authorities should be taken out of the block grant and be paid separately. The county council was, therefore, to have no power over the payment or withholding of grants to second tier authorities. This appeased the larger non-county boroughs who had little to fear from the mere strengthening of existing county council powers.[59]

When the local government white paper was published in June 1928 the AMC reaction was far more muted in respect to the poor law (health care) reform.[60] The non-county boroughs had accepted their failure to become poor law authorities as of right in return for the foiling of Ministry ambitions to promote the county council beyond the status originally suggested by Maclean.[61] The county

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59. See AMC council minutes, 24.11.1927, pp.225-235.
60. Proposals for reform in local government and in financial relations between the Exchequer and local authorities (cmd. 3134), PP (1928).
61. See, for example, PRO MH 57/147: Poor law reform 1926-1927, Secretary's papers. Minute of meeting with

councils and county boroughs, meanwhile, remained variously enthusiastic and ambivalent about their future role as major health and poor law authorities.[62] Whilst Ministry aims with respect to the reform of local health administration had been severely undermined by the intervention of feeling in the Conservative party, they had been effected to a considerably lesser extent by the negotiations with the local authority associations.

(ii) THE LOCAL AUTHORITIES AND GRANT REFORM, 1925-1929

Whilst the poor law (health care) reform produced separate and differing reactions from the CCA and AMC, involving some conflict of interests, the grant reform proposed in 1925 precipitated very similar responses. Officially the CCA came in to line with the AMC in accepting the principle of block grant reform. At a meeting in February 1926 the executive council accepted that a relaxation of detailed central control was unlikely except in the event of the introduction of a block grant, and as it was now an integral part of the Ministry's plans they should accept it. However, the executive council stated clearly that the conditions outlined by the committee chaired by Sir Arthur Chapman in 1921 should be met before full acceptance of the

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deputation from Non-County Boroughs Association, 30.11.1926.
62. See PRO HLG 8/88: Royal Commission on Local Government- local authorities, administration and finance. Note prepared by Sir Edward Forber, deputy secretary at the Ministry of Health, for Neville Chamberlain, 25.10.1928.

Ministry's reform was made.[63] In the summer of 1926 the case that no county council should lose income in a reform, existing grant aided commitments that had been entered in to should be provided for, extra grant should be provided for new obligations and that there should be an early revision of the block grant was made forcibly to Ministry officials. At the same time the AMC, which had been officially in favour of the block grant principle since 1919, voiced concern about the prospect of some county boroughs being worse off in grant aid as a result of the redistributive nature of the block grant. There was no explicit promise in the 1925 proposals of an additional sum which could guarantee local authorities against loss. As they stood the 1925 proposals suggested that as a result of the formula, which was at this time still solely based upon population and assessable value, the necessitous areas would be subsidised at the expense of grant aid to richer local authorities. The report of a special committee to the AMC council in June 1926 suggested that the block grant scheme was "a penalty upon progressive authorities", who had responded enthusiastically over many years to the stimulus provided by percentage grants, and built up vast and modern services. Liverpool, Manchester, Birmingham and Newcastle, for example, all stood to lose a great deal by the reform.[64]

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63. CCA Official Gazette (March 1926), pp.78-83. Report of the CCA executive council meeting, 17.2.1926.
64. AMC council minutes, 30.6.1926, p.169.

As a result the AMC council joined the CCA executive council in lobbying for safeguards. In addition in June 1926 the AMC council suggested that there should be additional grant aid with regard to transferred poor law services, and that any additional grant aid to poorer local authorities should be made outside the proposed block grant. Two deputations in July 1926 expressed AMC solidarity with the CCA position, and expressed dismay that central government should wish to make a permanent adjustment to the grant system against the interests of its principal partners in local government just because of temporary difficulties in the finance of administration in poorer areas. Chamberlain made sympathetic noises in the summer of 1926 and made it clear that he would introduce the block grant system more gradually, beginning with a three rather than a five year period, and would seek in his dealings with the Treasury to gain the additional sum which would guarantee the richer authorities against grant aid loss.[65] Despite this the AMC and CCA remained unsympathetic to the essential principle of the formula basis to the block grant. In October 1926, for instance, the AMC Council passed a resolution calling for the distribution of a block grant to be based on levels of local expenditure. This envisaged a percentage grant set for periods of years and would not essentially erode the grant basis of local authorities who had been served well by percentage

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65. See PRO MH 57/138, minutes of meetings between Neville Chamberlain, Ministry of Health officials and representatives of the AMC, 21.7.1926 and 29.7.1926.

grants. The AMC believed necessitous areas should be subsidised through additional grants from central government and not from within the existing pool of grant aid.[66] This made explicit what had been previously implicit in the conditions they had made on the acceptance of the block grant principle, that the local authority associations' aim was to have the block grant as a fixed grant on an expenditure rather than redistributive basis.

The positions of the AMC and the CCA on the block grant did not essentially change between 1926 and 1928 when plans for legislation were finally brought forward. Despite Chamberlain's offer of an additional sum of £5 million to guarantee against loss in the first five years of the block grant they remained gravely concerned about authorities who could potentially lose as a result of the redistributive intentions of the block grant. A CCA deputation in October 1928 suggested that in the long-term agricultural counties stood to lose a great deal and looked for a guarantee against loss for fifteen years. Chamberlain accused one of the CCA's principal speakers, Sir Percy Jackson of the West Riding of Yorkshire, of wanting only to secure the financial interests of his own authority whilst allowing the financial interests of other county councils to be allowed to go "rip". The CCA also shared the AMC's view that compensation for derating should be separated from the block grant. Compensation should be paid to individual authorities in accord with

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66. AMC council minutes, 28.10.1926, P.219.

their individual losses rather than allowed to be redistributed according to need to poorer authorities in the block grant. Chamberlain retorted to the CCA October deputation that this was tantamount to "cutting the baby in half" which inevitably "would extinguish its life". He looked rather to "trim the baby's hair".[67]

Essentially this is how Chamberlain and his senior officials responded between late 1928 and early 1929. To placate the interests of authorities who stood to lose grant income as a result of the introduction of a block grant Chamberlain endorsed the additional sum as a means of guaranteeing against loss, and further provided for additional grants which would ensure all local authorities a minimum gain over their 1929 grant aid position equivalent to 1s per head rate income. In addition he gave up the plan of introducing full formula distribution immediately and allowed for its more gradual introduction. This meant that local expenditure would remain the principal basis for grant distribution until 1937 and would not be fully phased out until 1947. In addition Robinson superintended the evolution of the minimum proportion formula which tied the aggregate level of block grant for each block grant period to levels of local spending.[68] The concessions were published in

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67. PRO HLG 43/2: Local government reform, CCA deputations. Minute of meeting between Neville Chamberlain, Ministry of Health officials and representatives of the CCA, 18.10.1928.
68. See PRO HLG 43/2, Robinson to S.M.Johnson, secretary to the CCA, 28.10.1928.

January 1929.[69] The reaction from the local authority associations was reluctant acceptance. The AMC council committee's view that they could expect little more from the government was endorsed, and in mid-January the CCA committee "decided to recommend the executive council to accept the Minister's concessions as being the best alternative apparently available".[70]

Chamberlain and his senior officials, therefore, won consent from the local authority associations to the reform of exchequer grants. However, as has been shown, it is inappropriate to characterise this consent as being based in the happy appeasement of the associations' aims. Even as the exchequer grant reform was being passed on to the statute books the associations remained profoundly unhappy that compensation for derating had been included within the block grant. In late 1928 they had also made a bid for the minimum proportion formula, which tied the aggregate block grant for each period to aggregate levels of local spending, to be implemented with regard to individual local authority block grant apportionments based on individual levels of expenditure.[71] More prosperous local authorities, who exerted decisive power within the local authority associations, this being by virtue of the nature of representation on the council and main committees in the case of the AMC, clearly wished to

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69. Local Government Bill, Amendments to part VI of the bill proposed by the Ministry of Health after discussion with the local authorities (cmd. 3257) PP (1929).
70. AMC council minutes, 8.5.1929, pp.87-88; PRO HLG 43/2, S.M.Johnson to Sir Arthur Robinson 10.1.1929.
71. PRO HLG 43/2, joint statement of CCA and AMC, 22.11.1928.

retain local expenditure as the principal basis of grant aid even within the block grant. Whilst Chamberlain's concessions had helped the local authority associations to save face, they still did not essentially meet their root aims.

Chamberlain and his officials, therefore, largely beat off the challenge from the local authority associations against a change in the essential basis of grant aid in the introduction of the block grant. Yet, it would also be inappropriate to applaud them for doing so as a defence of the essential redistributive aim of the block grant, and, therefore, of the financial interests of the poorer local authorities, which seemed to have been lost in the associations' own deliberations. For the concessions made to the richer authorities in 1928-1929, as well as failing to meet their true aim of an expenditure-based block grant, fatally undermined the ability of the block grant to help poorer authorities. As a result of making the introduction of formula distribution gradual, and until 1937 only 25% of the basis for block grant distribution, poorer authorities could expect little targeted relief in the short-term. Local authority equalisation through the block grant option appeared a distant and uncertain utopia. In short, the deal struck by Chamberlain over the block grant in early 1929, generally praised in terms of the retention of the essential principles of the proposals whilst balancing the interests of all concerned, should be viewed as one that ensured the reform fell between the

stools of percentage and redistributive grants. It pleased no-one and in particular left poorer local authorities highly vulnerable to financial crisis for some time to come, a prospect of which poorer local authorities were only too well aware.[72]

(iii) THE MINISTRY OF HEALTH, THE LOCAL AUTHORITIES AND THE BLOCK GRANT FORMULA, 1925-1929

The inadequacy of the block grant reform to meet the needs of poorer authorities was further compounded by the nature of the block grant formula. Sources in relation to the accountant- general's office's consideration of the factors to be included in the formula are more abundant for the early 1920s than for the late 1920s. However, certain key themes in Ministry consideration can be identified. First, Ernest Strohmenger, who remained as accountant-general until 1930, had established as early as 1920 that the formula should distribute the grant in accord with population and that this should then be modified by an indicator of the quality of population, which suggested relative population needs. In 1920 Strohmenger had focused on assessable rateable value per

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72. See, for example, The Times, 9.10.1928, p.7. This contains a report of a meeting of north-east local authorities, namely, Durham County Council and Darlington, Gateshead, Middlesborough, South Shields, Sunderland and West Hartlepool county boroughs. They expressed their doubts over the efficacy of even the original Ministry block grant proposals to achieve the desired grant distribution in relation to need, and commented on the lack of representation of their interests by the CCA and AMC.

head as the sole indicator of the quality of population. A national average of assessable rateable value per head could be established. Where a local authority fell below the average block grant apportionment could be increased to make up for the deficiency. In such a way block grant could be distributed in accord with need.[73]

At that time the determination of rateable value was made by a large number of local assessment committees. This raised two problems for the use of rateable value as a formula indicator. First, the creation of figures for rateable value was not made on a uniform basis, suggesting the likelihood of inequitable results in block grant distribution. Secondly, as long as power over the assessment of rateable value was in local hands there remained the potential for assessment to be made in accord with local interests in order to maximise the apportionment of block grant. The reform of rating and valuation was, therefore, essential to its utility to the block grant formula. After assuming office in late 1924 Neville Chamberlain took up the mantle of reform laid down by previous ministers of health. In 1925 Chamberlain introduced a bill which would have made borough and district councils local assessment authorities under the direction of the Board of Inland Revenue. This aroused considerable local opposition and crucially the Board of Inland Revenue pulled out of its intended role. Whilst local assessment was successfully concentrated in certain authorities, the only means of

73. See chapters two and three.

securing uniformity in local valuation established by the 1925 Rating and Valuation Act was a central valuation committee, which was a promotional rather than enforcement body.[74]

Chamberlain's failure to secure a system of uniform rating and valuation had important implications for the development of a block grant formula after 1925. Assessable rateable value per head could not be relied upon as the sole or even main indicator of local need in the formula. More than anything else Ministry officials were wary of potential local abuse of rateable value statistics to undermine fair distribution. This prevailing assumption of local behaviour also then underlay Ministry consideration of alternatives to rateable value per head as indicators of need. The level of local unemployment was an obvious choice, yet in its insertion in to the formula it was decided that only nationally derived figures would be used. The proportion of unemployment was, therefore, only to be measured in terms of the insured workforce. The uninsured unemployed who received assistance from poor law authorities were excluded on the grounds that local authorities would be able to massage their statistics of unemployed poor in order to distort the unemployment indicator in their favour. Similarly, the number of dependent children also presented itself as an obvious indicator of local need. Here, Ministry officials preferred to use statistics of

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74. See G.Rhodes, Evidence in Appendix Six of the Report of the (Layfield) Committee of Inquiry in to Local Government Finance (cmd.6453), PP (1976), pp.107-109.

the number of children under five, which, like figures for population as a whole, could be discerned from the Registrar-General's estimates, rather than the number of children in free elementary education for the reason that the number of the latter could be influenced by local education policies.

These indicator selections had at best questionable claims to best represent local needs. The exclusion of poor law figures meant the omittance of a significant measure of the number of unemployed in a given area. In addition, it could be argued that the level of unemployed poor was in principle a much better indicator of local need than the insured unemployed, for the former better reflected the extent of unskilled workers in a given area, and thus lower levels of personal working class income. The number of children under five indicator was also open to much criticism. In October 1928 the AMC protested that it could just as easily reflect local prosperity as poverty. Chamberlain robustly rejected this criticism but the evidence was not conclusive on either side. Moreover, it could be argued that in principle the number of children in free elementary education was a much better indicator of need, as it suggested the number of families unable to afford to pay for education. Its potential relevance as an indicator was enhanced by the fact that education was becoming an increasingly major spending item for local authorities.[75]

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75. See HLG 8/88, Note prepared by Sir Edward Forber for Neville Chamberlain, 25.10.1928.

Nevertheless, unemployment and the number of children under five were chosen as indicators of need and placed in to the formula with population. To these was added a weighting for the population per mile of road. This was a relatively reliable indicator of relative local needs and was derived again from national figures. Rateable value was retained as the final factor in the formula, but being the only factor derived from local figures was much reduced in importance from Strohmenger's original proposals of 1920. Overall, it can be argued that this cocktail of factors produced a formula that was not an ideally created basis for the distribution of block grant to the areas which needed it most. It was flawed by the failure of the 1925 Rating and Valuation Act, the inadequacy of government and local government statistics which this failure so cruelly exposed and the subsequent centralist assumptions which ensured the selection of questionable indicators of need.

The formula for block grant distribution may be further criticised on the basis of arguments put forward by Chester. First, Chester argues, that the redistributive aim was always going to be blighted by the fact that the block grant embraced also the aim of compensating local authorities for rate and grant aid losses. Whether the formula successfully targeted grant aid to authorities with higher need was, therefore, totally dependent on whether on the part of the block grant upon which it operated it yielded more grant aid than simple compensation would achieve. Chester suggests

that because the range of indicators that the Ministry used in 1929 were so limited and, indeed, so questionable population was made the principal factor in the formula. Distribution primarily on the basis of the quantity rather than the quality of population was always likely to lead to highly inconsistent outcomes in relation to the aim of meeting local need. Chester also suggests that a major deficiency of the 1929 block grant formula was its lack of negative factor weightings, although this may be seen as more of a post hoc judgment than something upon which contemporary debate turned.[76]

To their discredit, however, the local authority associations were chiefly concerned during 1928 with the forecasts of how much the block grant formula would direct grant away from local authorities which had done well under expenditure-based percentage grants rather than how well it would direct income towards high need areas. The AMC, for example, with the exception of its argument over the children factor and its detailed questioning of the mathematical weightings attached to each factor in the formula, concentrated on an attempt to place a sixth factor in to the formula. This was a weighting for the twenty five local authorities with the highest rates. Such a weighting would only have had a coincidentally beneficial effect on poorer local authorities. In principle it would have added a measure of local expenditure to the basis of the formula, and so

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76. D.N.Chester, Central and Local Government: Financial and Administrative Relations (1951), pp.256-280.

represented a further attempt by the local authority associations to erode the redistributive intent of the formula. Sir Edward Forber, the Ministry deputy secretary, roundly condemned the proposal, writing in October 1928 that "it is entirely contrary to one of the fundamental aims of the government scheme, viz, to encourage thrifty administration by eliminating expenditure entirely from the distribution of grant aid. Once expenditure were accepted as a factor for any part of the grant it would inevitably tend to become once again the predominant if not the only measure of need".[77]

Such a defence of the redistributive aim of the block grant by a senior Ministry official, of course, remained tarnished by the inherent weakness of the formula to realise that aim. The local authority associations did, however, seek and win the concessions of a review of the working of the block grant formula at an early occasion, and the institution of five yearly census to keep the population indicator up to date. Whether they did this so as to ensure that the block grant was achieving as best as possible the aim of distributing grant to areas of need, as commonly assumed, must now be open to serious question. It would be more appropriate to suggest that the more prosperous authorities, primarily represented by the local authority associations, were anxious to retain a watching brief over the block grant to ensure that the major part of the grant aid which they had gained under a

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77. HLG 8/88, Note prepared by Sir Edward Forber for Neville Chamberlain, 25.10.1928.

system of percentage grants continued to be received under the new block grant regime.

The analysis of the development of the block grant formula in the late 1920s and the response of the local authority associations completes the reconsideration of the achievement of reform. Such reconsideration suggests that views on the role of Neville Chamberlain as well as Ministry of Health officials in the formulation of the reform need to be revised. Chamberlain had strong party political reasons for promoting reform, which grew stronger in office. Moreover, his compliance with Ministry plans for reform grew out of parallel considerations within the Conservative party, based on similar values in the approach to social reform. The political nature of these shared values was revealed by the very different way in which the Ministry treated with Chamberlain and his Labour predecessor, John Wheatley. Finally, the importance of Chamberlain's own reasons for promoting reform was revealed, in particular, in relation to grant reform, where but for his desire for a cheap necessitous areas policy Ministry officials would have dropped proposals in 1926.

It is also clear that in the formulation of reform Ministry officials and Chamberlain showed little desire to meet the full plurality of interests, instead managing reform debate within limited bounds. In the early 1920s Ministry officials insulated their reform proposals from all external forces except for the local authority associations, who represented the authorities on whom

they would be reliant for the implementation of the reforms. The elaboration of shifts in the associations opinions goes a long way towards explaining shifts in Ministry intentions between 1919 and 1924.

From 1925 the formulation of policy was forced to take account of the views of rural Conservative backbenchers, but principally Chamberlain and officials again confined policy discussion access to the CCA and the AMC. The interests which would be appeased by the reforms were, therefore, inherently limited. The fact also that the Conservative backbenchers and the local authority associations primarily represented interests threatened by the reforms meant that their appeasement would be to the detriment of the original aims of the reforms. This was duly the case with regard to the prospects for aims in regard to local health care, which the Webbs themselves pointed out.[78] It was also the case with regard to the redistributive aim of the block grant. In the latter case, in addition, central incompetence in not carrying rating and valuation reform, allied to bureaucratic imperatives and poor representation of poorer local authorities in so opposing meant that the block grant formula was unlikely from its inception to achieve its redistributive ends. Consequently, the potential for success of what were from the start limited options for the reforms of health care and local finance

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78. S. and B.Webb, English Poor Law History, Part II, Volume II (1929), p.990.

was further eroded in the reform formulation by a bounded pluralist policy process.

Further, the implications of placing an additional sum in to the block grant, and of providing for additional grants to prevent local authority losses, which had also been forced by the local authority associations, for the success of the block grant as a grant aid control were not a matter of debate but it is questionable as to why not. The final aim of the 1929 reforms of securing through grant reform greater local autonomy seemed assured of success. However, even in 1929, there were critics in local government who suggested that local autonomy and lax central control could lead to a decline in standards of local health provision. Sir Arthur Robinson's private comment to A.N.Rucker, Chamberlain's private secretary, in response to the suggestion that the Minister's powers ought to be strengthened further was simply to say that "local authorities would very reasonably object to this under my minister and you can yourself easily inquire what it might mean under a Labour minister.[79] Further bureaucratic suspicion of the Labour party, therefore, left the criticism to be tested. In 1929 the optimism for successful implementation of the reforms in terms of all of their prescribed aims, recession ahead or not, was built on shifting sands.

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79. PRO MH 55/9: Papers relating to the consideration of the clause in the 1929 Local government Act as to power to reduce grants when services are unsatisfactory. Robinson to Rucker, 21.1.1929.

CHAPTER FIVE

THE IMPLEMENTATION OF EXCHEQUER GRANT REFORM

This chapter reconsiders, first, the view that the block grant introduced in 1929 proved during the 1930s to be an effective means of controlling exchequer grant aid, and. secondly, the view that the block grant was an effective means to redistribute grant aid more towards the poorer local authorities, which was eroded only by the serious effects of the recession. The second part of the chapter also examines the view that the investigation in to the working of the block grant formula between 1935 and 1937 yielded a further improvement of the block grant's redistributive capacity in the light of the experience of the recession years. The reconsideration is based primarily on the paucity of previous research and the more critical approach to implementation which conclusions on formulation suggest is appropriate. In particular, analysis of the bureaucratic, political and local authority association inputs in to the formulation of the block grant has already revealed why and how the block grant contained inherent defects as a means of grant income redistribution, which the recession then served only to exacerbate. Similar analysis of policy inputs in terms of the concept of an inter-governmental policy network in relation to the revision of the block grant formula in the mid-1930s appears a necessary complement. Finally, the chapter considers the view that the experience of the implementation of the block grant

during the 1930s, both in terms of grant aid control and grant income redistribution, endorsed the principles of block grant reform in 1929 as a model for future reform.

1. TREASURY CONTROL AND THE BLOCK GRANT

The block grant had three elements: compensation for derating; compensation for discontinued grants; and an additional sum. At first sight, the block grant appeared to represent a large increase in grant aid to local government. This was, however, principally due to the element of compensation for derating. Although paid to local government it was seen as a subsidy to industry and agriculture and, therefore, should be omitted from a consideration of whether the block grant assisted in the control of grant aid to local government. Attention instead should be focused on the second and third components of the block grant. The second component of the block grant was the compensation for discontinued grants. It covered fewer local authority aided services than the Treasury would have liked. Indeed many elements of the block grant merely consolidated fixed items such as the assigned revenues and the agricultural rates compensation grants.[1] However, the block grant still held the potential to limit grant aid for local authority health and road services. By fixing grant aid for

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1. For an endorsement of the limited nature of the block grant in 1929 see R.Jackman, 'Local Government Finance', in M.Loughlin, M.D.Gelfand and K.Young (ed), Half a Century of Municipal Decline, 1935-1985 (1985), pp.161-163.

periods of years the exchequer intended to make savings against what grant aid would have been had central percentage grants continued to rise annually in accord with local spending. The third component, the additional sum, £5 million p.a. in the first block grant period, did represent an increase in exchequer aid to local government, but had been assumed by the Treasury throughout the 1920s to be a necessary bribe to local government to accept the block grant, which would be rapidly cancelled out by the savings in relation to health and road grants.[2]

During the 1930s the expectations of the Treasury in respect to the second and third components of the block grant were, however, cruelly denied. Indeed, it is ironic that it was as a grant aid control that the unforecastable defects of the block grant reform were exposed by the recession. In 1930 the block grant was set at £45.1 million p.a. for the three years 1930/1931 to 1932/1933. In 1931, in response to the recession, the new National Government considered it essential to impose economies in government expenditure so as to reduce the burdens on the economy and so facilitate rapid recovery. A call for economy was extended to local government and indeed many local authorities imposed their own economy policies ahead of the Ministry of Health circular. As a result aggregate local authority spending on percentage and specific grant-aided services dropped for the first

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2. See, for example, PRO T 161/248/S.26701: Control of local authorities by government departments, 1924-25 and 1929. A.Hurst to Sir George Barstow, 30.1.1925.

time since the First World War. Spending reductions were maintained in both 1931/1932 and 1932/1933, with the result that associated grant aid was also reduced.[3] At the same time the Government imposed emergency cuts in teachers and police salaries in a similar manner to those imposed on the recommendation of the Geddes Committee a decade before. The emergency situation made such cuts acceptable in local government.[4]

The effect of these events was to show the advantage of the flexibility of percentage and specific grants to respond to public expenditure crises. They could go down as easily as they went up. In these circumstances the fixity of the block grant for three years proved a positive handicap to limiting or reducing grant expenditure. For each of the two years 1931/1932 and 1932/1933, therefore, the exchequer was pumping in to the local authorities at least £5 million more than if there had been no reform of exchequer grants and the former grants had continued. On top of this additional grants paid in the first grant period totalled £421,436. In addition, it is reasonable to assume that if the former health percentage and road grants had still been in use they would have fallen in proportion to the fall in the aggregate amount of grants outside the block grant. Consequently, the exchequer was also providing an extra sum to local government equivalent to the difference

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3. See B.R.Mitchell and P.Dean, Abstract of British Historical Statistics (1962), p.415.
4. See, for example, J.Stevenson, British Society 1914-1945 (1984), pp.306-317.

between the fixed compensation for grants in the block grant and the hypothetical level of grants had they still been in existence.(see figure 2) In sum, the block grant represented a subsidy to local government in the region of £6-7 million p.a. in the early 1930s, an amount equivalent to over 5% of all government grants, and this in years of falling prices. The block grant rather than serving as a negative grant control acted as an unintentional counter-cyclical spending device during the worst years of the recession.

Figure 2 The Block Grant and Total Exchequer Grant Aid to Local Government, 1930-1939

YEAR (ending)	TOTAL GOVT GRANT (£m)	BLOCK GRANT (£m)
1930	107.8	-
1931	130.2	45.1
1932	126.6	45.1
1933	120.5	45.1
1934	121.6	45.3
1935	125.0	45.3
1936	132.9	45.3
1937	135.6	45.3
1938	136.1	47.2
1939	140.2	47.2

(Source: B.R.Mitchell and P.Dean, Abstract of British Historical Statistics (1962), p.415)

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At the same time problems in the ascertainment of the value of formula factors meant that throughout much of the first block grant period it became difficult to make

anything other than provisional block grant apportionments to individual local authorities. By 1932 it had become clear to senior Treasury officials that this manner of implementation had on balance led to more over-payments than under-payments. Further, there were strong Ministry of Health arguments that immediate correction in the year following overpayment would lead to a serious dislocation of the financial policies of some of the local authorities concerned. Thus, with regard to Glamorgan in 1931 and Durham in 1932, the Treasury was prevailed upon to make good its losses by staggered reductions of grant. Such technical difficulties in implementation merely served to reinforce the emerging realisation that the block grant was not the panacea to all the ills of central grants that the Treasury had previously thought.[5]

Senior Treasury officials fought to minimise exchequer losses made because of the block grant by a number of means. All of these suggested the primacy of central public expenditure control against the financial interests of local government. The first part of the damage limitation exercise, begun even before the block grant had been officially introduced, involved the non-payment of remanet grants. These were the grants in respect of health and road services, and local taxation, that still remained to be paid in 1930/1931 for the

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5. PRO T 161/1228/S.33386/4: Local government reform, financial relations between the exchequer and local authorities, January 1931-May 1939. Alford (Ministry of Health) to Beresford (Treasury), 2.1.1931 and 30.3.1932, and Beresford to B.W.Gilbert (Treasury), 18.4.1932.

financial year 1929/1930. They totalled £1,982,000. In January 1930 A.W.Hurst, a principal assistant secretary, pointed out the opportunity provided by the clause in the Act which stipulated that the full amount of the block grant for each year should be paid in the year with respect to which it was being paid. Hurst suggested that the clause made the full amount of the block grant a ceiling to the exchequer's annual liability. Therefore, he "saw no reason why we the exchequer should be called upon to pay in 1930 not only the balances of grants due in respect of 1929 but also a full year's block grant under the new system. We, therefore, propose to aggregate all the outstanding balances and only to pay so much of the new block grant on account each year as would with these outstanding balances make up a full year's total of the new grant". The strategy which in effect entailed the postponement of the payment of the remanet grants indefinitely was approved by Sir Richard Hopkins, then controller of supply and finance. He saw it as "the best policy to carry the liability forward as long as we can".[6]

In October 1930 Ernest Strohmenger, by then deputy secretary at the Ministry of Health, informed the Treasury that the strategy to withhold all of the remanet grants risked considerable opposition from the local authority associations. He proposed that the sting be

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6. PRO T 161/1228/S.33386/3: Local government reform, financial relations between the exchequer and local authorities, December 1929 to November 1930. A.W.Hurst to Mr Upcott 2.1.1930, and R.N.V.Hopkins comment on Hurst's paper 2.1.1930.

drawn out of any lobby for complete payment by placating those authorities to whom the remanet grants were most important. Accordingly, it was decided that where the remanet represented more than 1/12 of a local authority's block grant income only 1/6 of the remanet would be held back by the Treasury. Strohmenger firmly believed that this would stave off opposition whilst still allowing the Treasury to keep back approximately £1.68 million indefinitely.[7] His calculations proved correct. Indeed, there is evidence which proves that the remanet grants remained unpaid as late as 1936, and there is no clear evidence that the debt to local government was made good even after that date.[8]

In the early 1930s the successful strategy with regard to remanet grants gave Treasury officials some comfort against the knowledge of the block grant's aggregate subsidy to local government and the unavoidable phenomenon of over-payment of grant in respect of individual authorities. It did not, however, in any way compensate for the fact that the block grant during its first period failed to reduce or halt the growth in exchequer grant aid to local government. Indeed it operated in rather the opposite way. This experience led to a second strategy to minimise the failure of the block

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7. ibid, E.J.Strohmenger to A.W.Hurst 15.10.1930.
8. PRO T 161/1228/S.33386/4, correspondence between S.H.G.Hughes, by then accountant-general at the Ministry of Health, and B.W.Gilbert, of the Treasury, November-December 1936. Hughes suggested that the remanet be finally be paid as part of new arrangements concerning the road fund. Gilbert replied that "if and when we have to deal with these remanets, it will as I see it, have to be done through the ordinary block grant vote".

grant as a grant aid control. This involved a minimalist approach to the setting of the block grant for its second period. In 1933 the amount for the additional sum, the one flexible component of the grant, was set strictly in line with the minimum proportion formula laid down in the 1929 Act. This was done in spite of heated Parliamentary debates early in 1933 in which Labour MPs in particular condemned the government for not using the block grant mechanism to make some additional subsidy to the local authorities who were in deep financial crisis as a result of the cost of public assistance to meet the enormous increases in unemployment.[9]

Any Treasury euphoria over this approach to the block grant in its second period was quickly dispelled, however, in June 1933 by a one-off supplementary Parliamentary vote of £500,000 to help local authorities in distressed areas in England, Scotland and Wales. Sir Edward Hilton Young, the Minister of Health, had not been persuaded by the arguments of the distressed areas to increase grant aid through the block grant but had been unable to justify no extra assistance, even given the constraints of public expenditure policy.[10] More importantly, perhaps, the minimalist approach to the aggregate level of the block grant, however, failed to turn the block grant in to a success in the second grant period either. For the period 1933/1934 to 1936/1937 the

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9. Parl.Deb., 1932-33, 274, cols.1617-1681.
10. PRO HLG 30/43: Unemployment-equalisation of burden. Edward Hilton Young to Lord Mayor of Manchester, 22.6.1933.

additional sum was set at £5.3 million, increasing the block grant slightly to £45.3 million. During the second period local spending, and, therefore, grants outside the block grant, rose again, especially in 1935/1936 and 1936/1937.(see figure 2) Here it is reasonable to assume that had the former health percentage and road grants still been in use they would have risen in proportion to the rise in the aggregate amount of grants outside the block grant. In this context the exchequer stood to make grant gains on the basis of the difference between the fixed compensation for health and road services grants and the hypothetical level of the grants had they still been in existence. However, at the most such gains were in the region of £2-3 million p.a. between 1935 and 1937. This was more than cancelled out by the £5.3 million of new money being paid each year through the block grant, and the £206,556 paid in additional grants. Consequently, even in the second grant period the block grant still proved to be a greater expense to the exchequer than if there had been no grant reform at all.

Treasury despondency was intensified when in March 1936 the estimated figures for local rate and grant-borne expenditure for 1935/1936 were received. It was upon these figures that the variation of the additional sum in the block grant in the third period between 1937/1938 and 1941/1942 would be based. The upturn in local spending in the critical base year of 1935/1936 meant that even if a minimalist approach was taken to the increase in the additional sum in line with the minimum proportion

formula then the additional sum could be expected to increase by some £4.5 million to take the block grant as a whole towards £50 million p.a.. B.W.Gilbert, a principal assistant secretary at the Treasury, described the news as "a real shock both to the Ministry and the Treasury".[11] The extent of the shock to the Treasury was fully revealed at the end of the month when Neville Chamberlain, by then Chancellor of the Exchequer, informed the Minister of Health, Sir Kingsley Wood, that "it sets a severe limit to any other addition I can contemplate to the general cost of the social services".[12]

The setting of the block grant for the third period was made from the beginning on the assumption of a minimalist approach to the additional sum. This was not expected to augur well for the utility of the block grant as a grant aid control. However, senior officials at both the Ministry of Health and the Treasury manoeuvred in 1936 to make what gain they could from the boon to local government finance that the increase in the additional sum would represent. In February 1936 S.H.G.Hughes, the accountant-general at the Ministry of Health since 1930, suggested to Sir George Chrystal, Robinson's successor as permanent secretary, that the opportunity could be taken to merge the contributions made by local authorities to the Unemployment Assistance

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11. PRO T 161/931/S.42351: Block grant revision 1936-1937, England and Wales. Gilbert to Barlow, 5.3.1936.
12. PRO HLG 52/255: 1929 Local Government Act, Investigation of exchequer grants, January-June 1936. Neville Chamberlain to Sir Kingsley Wood, 30.3.1936.

Board under the 1934 Unemployment Act in to the block grant as of the beginning of the third period.[13] This appeared to represent no financial gain to the exchequer as it would merely entail a change in the method of contribution. Instead of local authorities making individual payments to the Unemployment Assistance Board they could be deducted en masse from the block grant and then paid to the Unemployment Assistance Board. However, in early 1936 Liverpool County Borough Council was renewing a campaign to have local authority contributions to the Unemployment Assistance Board abolished. Hughes told Chrystal in March 1936 that "I think it will be found increasingly difficult as time goes on to insist on full payment". In this context "the large amount of new money to be added to the block grant afford[ed] a unique opportunity" of making local authority contributions to the Unemployment Assistance Board permanent, thus ending controversy over their payment and avoiding the possibility of their abolition, without soliciting undue opposition from local government. Hughes assumed that local government would not provide concerted opposition to the reduction in an increase in the block grant which they had yet to enjoy.[14] In such a way, then, the Treasury and Ministry of Health sought to offset the losses through the additional amount to be paid in the third grant period with the gain of certain continuations

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13. ibid, S.H.G.Hughes to Sir George Chrystal, 20.2.1936.
14. ibid, 4.3.1936.

of local authority contributions to the Unemployment Assistance Board.

The problem for the Ministry of Health was that this revision of the block grant would benefit county boroughs more than counties, county borough contributions on an individual basis being higher than county contributions. The merging of contributions in to the block grant would spread the liability unfairly to county councils. Consequently, Hughes also proposed that the abolition of grant with respect to trunk roads, which the Ministry of Transport was proposing to make a national responsibility, should also be incorporated within the block grant. This would benefit the counties and offset their increased liability through the block grant for contributions to the Unemployment Assistance Board.[15] The Treasury welcomed the proposals and added the proposal that the local taxation duty in respect of male servants licence duties be abolished and added to the block grant from 1937.[16] B.W.Gilbert, particularly pleased about the plan with respect to Unemployment Assistance Board contributions, concluded to Hughes in July 1936 that in the circumstances "the final settlement with local authorities is likely to be a bargain...the question is mainly one of doing the best we can as the figures we finally fix on is embodied in a statute".[17]

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15. ibid
16. PRO T 161/931/S.4235l?2: Block grants revision 1936-1937, England and Wales. Gilbert to Barlow, 7.1.1937.
17. PRO T 161/1228/S.33386/4, B.W.Gilbert to S.H.G.Hughes, 21.7.1936.

The result of this Ministry of Health-Treasury strategy was to gain some compensation for exchequer interests in the block grant settlement for 1937 for the fact that overall the increase in the additional sum negated the block grant's utility as a grant aid control. Even then the reduction from the annual amount of the block grant of £2,187,000 for Unemployment Assistance Board Contributions and £133,000 for road grants, with the addition of £115,000 in respect of the abolition of the male servants license duty, left the total block grant for the third period at £47.2 million p.a., an increase of £1.9 million on the annual amount for the second period.[18] To further confound Treasury hopes of the block grant's fixity being an asset grant-aided spending outside the block grant levelled out in the first two years of the third period as War approached and local authorities cut back on peace-time schemes.(see figure 2) Once again this left the block grant, being fixed, inflexible to a change in local authority spending, representing a greater contribution to local authority finances - a contribution exacerbated by the £168,825 paid in additional grants in the third period - than if there had been no exchequer grant reform at all in 1929. Rather than providing a grant saving for the exchequer, in the late 1930s, as in the early 1930s, the block grant proved to be a liability.

Overall, then, analysis suggests that in its implementation the block grant as a grant aid control far

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18. Parl.Deb., 1936-37, 320, cols.2021-2119.

from being successful was an almost lamentable failure. Indeed in the early 1930s the ceiling that the block grant placed on grant aid was so lofty that it in fact substantially increased the costs to the exchequer of funding local services. By 1939 it had become clear to the Treasury that if the block grant was to have any long-term benefits for expenditure control they would be completely unpredictable anyway. The fatal flaw in Treasury thinking had been the assumption that local authority grant spending, where aided by the supposed money spinning device of the percentage grant, would continue to spiral as it had done in the 1920s. This was not the case in the 1930s. The principle of fixing grants for periods of years, considered essential to grant aid control in the 1920s, was, therefore, found wanting in the 1930s.

It is also important, however, to emphasise how the Treasury attempted to claw back losses made on the block grant through other means, in particular with regard to the retention of the remanet grants and the adoption of a minimalist approach to the increase in the block grant at the beginning of each period. Of equal note was the manner in which both the Treasury and the Ministry of Health manipulated the block grant, especially in 1937, to attain other ends in the financial interests of the exchequer. The manner of block grant implementation, even in relative failure, suggested a continued commitment to the self-interests of the bureaucratic elite through pragmatic and incrementalist means.

2. THE BLOCK GRANT AND LOCAL AUTHORITY FINANCES

This analysis of the block grant as a grant aid control during the 1930s necessitates immediate revision of the context in which the effect of the block grant on local authority finances is to be seen. It is not a matter of dispute that in simple money terms every county borough and county council was a net gainer from the block grant in the period up to 1937. Further, it is now possible to suggest that at an aggregate level local government was also a gainer from the block grant relative to the hypothetical level of grant aid on discontinued grants had they in fact been continued during the 1930s. Most, if not all, local authorities, it may be said, derived some benefit from this. As a result it is appropriate to raise the significance of debate upon the effects of the block grant on the finances and financial policies of local authorities to the same prominence as that of debate upon public works programmes and the special areas grants from 1934. Although the block grant money was in aid of revenue expenditure it had the potential for exerting a material effect on the continuation and extension of existing services as well as the level of the local rate.

However, the extent to which individual local authorities benefited from the block grant is highly problematical. Two complementary approaches to answering this question may be attempted. First, one may inquire

in to the working of the block grant formula to ascertain how it distributed that part of the grant upon which it was operational between different local authorities. Then to discover what real gains it provided for local authorities one could compare in the case of each local authority the amount received through the operation of the formula against what would have been received from a simple compensation for rate and percentage grant losses. Alternatively, one could attempt to compare amounts received through the block grant as a whole as well as the operation of the formula against hypothetical figures for percentage grants and industrial and agricultural rate income in the 1930s had there been no reform in 1929.

The second approach would be highly desirable, especially given the sharp change in trends in percentage grants in the 1930s outside the block grant, which tend to suggest that local authorities gained by the block grant, and the volatility of local economies in recession and recovery. Many local authorities complained in the mid-late 1930s that the compensation for industrial derating enshrined in the block grant was hugely inadequate set against the rate income which could have been accrued from revived industry. However, an evaluation of the impact of the block grant on local finances on this basis is blighted by the absence of reliable statistics. Consequently, the discussion of grant distribution presented here is informed only by the first approach, and then to a great extent by the

conclusions based on this approach of Chester.[19] Though it is important to emphasise its incompleteness without reference to the second approach.

It is to be remembered that distribution of the block grant in the first two block grant periods was prejudiced by the settlement reached in 1929 upon the nature of the block grant formula and of its introduction. Only 25% of the block grant was to be distributed according to the formula. It was inherent in this settlement, therefore, that the majority of the block grant would continue to be distributed in accord with local patterns of grant-aided expenditure pertaining before the 1929 Act. Moreover, the formula was a questionable indicator of need, given that, in particular, so much weighting was given to population in the absence of the ideal need indicator, rateable value assessed on a uniform basis.

It must be noted that the formula was designed specifically with the first block grant period in mind. It was a rough, but nevertheless serviceable, index of local need for 1929, this being the only criterion on which a formula could be tested in the absence of uniform rating and valuation. As a result, although only 25% of the block grant was distributed according to the formula, in the first period the block grant showed some ability to discriminate between poorer and richer local authorities, providing much greater additions in terms of rate per head to the finances of such authorities as

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19. D.N.Chester, Central and Local Government: Financial and Administrative Relations (1951), pp.256-280..

Durham and Gateshead than to those of more prosperous authorities like Eastbourne and Bournemouth. However, as Chester points out, if money gains through the operation of the formula are set against rate and grant losses, then even in the first grant period it can be seen that local authority gains made through the operation of the formula were highly inconsistent in terms of attempting to help the poorest authorities most. The inherent defects of the formula mitigated against success even in the first period.[20]

In this context, it may be seen the large increase in unemployment and consequent pressure on public assistance and other services in the necessitous areas served to exacerbate the financial problems of poorer authorities. The lack of real assistance gained through the block grant brought forward a prompt response from the necessitous areas in favour of its reform. In June 1932 a deputation of M.Ps representing local authorities in necessitous areas met with Sir Edward Hilton Young, the Minister of Health. The local authorities represented were Berwick-upon-Tweed, Bilston, Bishop Auckland, Cardiff, Chester-Le-Street, Durham, Gateshead, Hull, Jarrow, Lincoln, Liverpool, Manchester, Newcastle, Norwich, Nottingham, St.Helens, Sheffield, Stoke-on Trent, Stockton-on-Tees, Tynemouth, Wallsend- on-Tyne, Walsall and West Ham. The M.Ps carried with them the fruits of a meeting held earlier in the month. That meeting had heard what became known as the Salford

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20. ibid

proposal, which envisaged a complete revision of the block grant formula so as to produce a nationwide equalisation of the public assistance rate. This had been dropped in favour of a more moderate proposal for an immediate inquiry in to the block grant formula, with a view to increasing the weighting in the formula for unemployment. This was the proposal put before Hilton Young.

Hilton Young's response was a cautious defence of the working of the block grant formula. He was, of course, able to point to certain evidence that local authorities in necessitous areas had gained substantially more in terms of local rate per head than more prosperous authorities. He implored local authorities to exercise greater economy in local administration. He then stated that any revision of the formula must await further experience. He was optimistic that the formula would take account of the great increase in unemployment and the financial needs of local authorities in necessitous areas in its distribution of grant for the second period.[21]

It was, however, indicative of the fact that the formula had mainly been constructed to ensure the realisation of limited redistributive ends in the first block grant period that the same formula did not bear out Hilton Young's optimism for the second period. The formula was not a timeless index of local need, and its

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21. PRO HLG 30/42: Unemployment in the distressed areas. Minute of deputation of MPs calling for the investigation of the block grant formula, 30.6.1932.

success in terms of directing grant income towards areas of high need was subject to random influences acting upon individual formula factors. As Schulz has already shown such random influences resulted in the formula skewing grant distribution towards areas of population growth in the second period. As population migration was essentially from the north to the south in the 1930s the formula tended to exacerbate higher funding of southern local authorities, conspicuous by their absence from lists of necessitous areas, who already benefited most from the block grant as in the second period it was still 75% distributed on an expenditure basis. As a result, for instance, between the first and second grant periods Croydon, one of the more prosperous county boroughs had its block grant allocation increased despite relatively low service need, whilst such necessitous areas as Burnley, Newcastle-upon-Tyne, Rotherham, Salford, Cardiff and Merthyr Tydfil actually suffered a decrease, despite a continuing high call on public assistance in 1933.[22]

Local authorities who had been placated by Hilton Young in 1932 protested. A conference of high-rated urban authorities from Yorkshire and Lancashire in March 1933 was followed by one later in the month of Tyneside boroughs, which called for the revision without delay of the block grant formula to give substantially more weighting to the factor of unemployment. Many now suggested that this should result in the equalisation of

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22. Municipal Review (January 1936), p.10.

the rate between local authorities.[23] The Daily Herald, reporting on the conference of Yorkshire and Lancashire authorities, revealed that "speakers urged drastic action for the equalisation of the poor law burdens among all municipalities in the country, and the inadequate steps taken by the Association of Municipal Corporations to deal with the matter were sharply criticised." The AMC was seen as openly endorsing a method of distribution which mainly benefited its more prosperous members.[24] It was in the context of this opposition and the manifest failure of the formula to direct block grant money for the second period to local authorities of high need that Hilton Young made his decision, with Cabinet approval, to make a special supplementary grant available to local authorities in the necessitous areas outside the block grant mechanism. However, with the review of the working of the block grant formula coming up in 1935, a statutory requirement under the 1929 Act, there was a ready facility for the needs of local authorities to be suitably met within the block grant from the beginning of the third period.

The potential for the block grant to more successfully meet the aim of grant aid redistribution in the third period was further heightened by the fact that the formula would be then responsible for the distribution of 50% rather than 25% of the block grant. However, this and the formula review were greeted with trepidation

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23. PRO HLG 30/43, Robinson to Gibbon, 20.3.1933.
24. ibid, copy of Daily Herald report, 10.3.1933.

rather than enthusiasm by the Ministry of Health at the beginning of the review. Distribution of 50% of the block grant by means of the unrevised formula in the third period was predicted as likely to lead to a highly undesirable pattern of distribution. Social and economic change during the second period acted on the formula factors in such a way as their weightings under the 1929 Act would continue to direct grant aid away from the poorer urban authorities.[25] Further, the fact that the formula would primarily distribute grant on the basis of population meant that the sparsely populated rural counties stood to make "almost embarrassingly large" losses.[26] However, officials knew that any attempt to use the review to prevent the formula working in this way was fraught with problems.

First, there was the issue of how redistributive the formula should be in the light of experience in the 1930s. The increase in calls by poorer local authorities for the block grant to facilitate the equalisation of rates nationwide suggested that the redistributive aims of the block grant should go considerably further considerably quicker than envisaged in 1929. In July 1936 Hughes calculated that to reduce the rates in all urban areas to a maximum of 16s in the £ per head would require a subsidy of £22 million p.a., paid for either

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25. PRO HLG 52/254: Investigation of exchequer grants under Section 110 of 1929 Local Government Act, August 1935-December 1935. Hughes to Robinson, 9.11.1935.
26. PRO HLG 52/256: Investigation of exchequer grants under Section 110 of 1929 Local Government Act, July 1936-December 1936. Report on progress of formula investigation by Hughes, 25.7.1936.

out of exchequer funds or through a wholesale shift of resources from relatively more prosperous authorities.[27] The former was in contradiction of bureaucratic imperatives in public expenditure policy and the latter would risk united and unmoveable opposition from the local authority associations.

In addition, Ministry of Health officials were very conscious of the constraints imposed by the additional grant provisions included in the 1929 Act. These had ensured local authorities against loss. Any radical reform of the formula which enhanced its redistributive qualities would lead to heavy local authority grant losers, who would have to be compensated by additional grants. This would be opposed by the Treasury. In such way, then, one of the apparently more minor concessions made in 1929 to more prosperous authorities, who feared losses under a block grant, served to prevent any major enhancement of the redistributive potential of the block grant. Radical reform to meet the needs of poorer local authorities was, therefore, not feasible. As a result, Ministry of Health officials based consideration of the revision of the formula on the assumption that it should simply more equitably distribute the block grant in accord with local needs "without placing an undue burden on any of the more wealthy areas".[28] The approach taken to formula review by the Ministry was, therefore, in the

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27. ibid, Hughes to Sir George Chrystal, 27.7.1936.
28. ibid, report on progress of formula investigation by Hughes, 25.7.1936.

nature of a further incrementalist adjustment from the policy inititiated in 1929.

Secondly, even in embarking on this limited reform of the block grant, there were technical difficulties to be overcome. As Hughes informed Sir George Chrystal in July 1936 the "wide differences in the present level of rates, stage of development of services, local conditions and varying requirements together with the important initial complication of the combination in the grant of a proportion of losses of rates and grants, with money distributed on a needs formula basis, make it impossible to produce anything to which objections cannot be raised on the grounds of inconsistency or its indirect results".[29] Such problems continually hampered Ministry consideration and testing of formula revision between 1935 and late 1936. By late 1936, however, Hughes and the accountant-general's division had successfully evolved a number of proposals which suited their limited aims. These included a retention of the weighting in the formula for unemployment, provided for in the 1929 Act, with an increase in the weighting for this factor with respect to necessitous areas. In addition, Hughes proposed a superweighting for excessively low rateable value, the inclusion of the number of children between five and fourteen in elementary education in the children factor, an increase in the weighting for the population sparsity factor for counties and the addition of an entirely new factor of the rate of population decline.

29. ibid, Hughes to Sir George Chrystal, 25.7.1936.

Such proposed revisions to the formula would as practicably as possible meet Ministry aims.[30]

Finally, the nature of the Ministry's consideration of revision was from the beginning prejudiced by the continued desire, first exhibited in the formulation of the 1929 Act, to gain consent from the local authority associations, thereby legitimising formula revision. This was also to the detriment of any more radical aims of assisting local authorities in areas of high need. Yet, the even greater importance which the Ministry of Health now attached to sustaining an apparent consensual peace in inter-governmental relations threatened even the limited revision of the formula which the Ministry was envisaging. The Ministry was entirely dependent upon local authorities for the successful implementation of many other features of the 1929 Act, and officials recognised that their proposals for revision would arouse considerable opposition from the local authority associations, which represented primarily the interests of local authorities who stood to lose relatively by the Ministry's proposals. Such opposition and broad conflict in relations which would follow were to be avoided at all costs.

There was very good reason to expect local authority association opposition. More prosperous authorities had turned down Hilton Young's suggestion in 1933 that they contribute the equivalent of a 1/2d rate to add to

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30. ibid, Hughes' note of present position of block grant investigation, 18.9.1936, and S.H.G.Hughes to Arthur Collins, 7.10.1936.

Parliament's supplementary vote to assist the necessitous areas.[31] Ministry hopes of a more enlightened approach by the associations to the aims of the formula in 1935-1936 than they had showed in the late 1920s and in 1933 were not high. S.H.G.Hughes stated in July 1935 that "as the problem is one of distribution it will not be surprising if there is a considerable body of opinion in support of leaving things substantially as they are while, at the same time, it may be expected that there will be pressure from committees of distressed area authorities for modification of the formula in their favour, the representative associations being either unconvinced by their case or unwilling to recommend changes which would involve a lower grant to the majority for the benefit of the minority".[32]

Consequently, Ministry officials decided that they would not actively promote their proposals until it was clear what the local authority associations would accept, and as a result the tenor of Ministry debate was for much of 1936 kept secret. This meant that the formulation of policy on the revision of the block grant formula was limited not only by the broad imperatives of senior Ministry of Health officials but also by what could be agreed by consensus in inter-governmental relations. Ministry officials, nevertheless, sought to direct the local authority associations towards a consensus which

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31. PRO HLG 52/254, Hughes to the secretary, 18.11.1935.
32. ibid, Hughes to the secretary, 30.7.1935.

accorded with the redistributive aims of the formula in general and Hughes's detailed proposals in particular.

This was done by three principal means. First, in turning the initiative in the review over to the local authority associations, with officials providing whatever data they wanted, the Ministry effectively ensured that whatever conflict would emerge between the interests of different local authorities would be directed inwards and not at the Ministry of Health. This would hopefully produce some kind of consensus with which officials could then treat, or, as Hughes put it in November 1935, allow "their ultimate suggestions to cancel out and to some extent afford a peg on which to hang our proposals".[33] Secondly, in giving the local authorities the initiating rather than reactive role, greater power was given to the experts advising the local authority associations. A joint committee of financial advisers was established which Ministry officials thought "might be better able than other bodies to take a broad and unbiased view of the position", and which in turn could then influence the different associations to consider revision of the formula not solely in terms of the vested interests which they represented.[34] Finally, the financial advisers committee offered Ministry officials a point of contact at which they could direct a continuous flow of information and suggestions which pointed local authority

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33. ibid, Hughes to the secretary, 18.11.1935.
34. PRO HLG 52/255, minute of conference held at the Ministry of Health between Ministry officials and representatives of the Institute of Municipal Treasurers and Accountants, 29.4.1936.

consideration towards the aim of more effectively assisting the necessitous areas through the block grant formula.

Though different in form from the approach to relations in 1929 the Ministry's strategy again represented an attempt to manage intergovernmental relations towards centrally defined aims. This strategy was not without its problems. First, it was not until the spring of 1936 that the local authority associations took up the gauntlet thrown down by the Ministry to participate in the review and made full usage of Ministry information.[35] Secondly, the committee of financial advisers which was then set up, composed principally of senior local authority treasurers under the chairmanship of Arthur Collins of the AMC, moved only slowly towards the aim of improving the grant formula's redistributive facility. Only in June 1936 did a discussion between Gilbert of the Treasury and Hughes of the Ministry of Health yield the conclusion that "there was a general feeling among the financial advisers that some of the grant would have to be diverted from the richer to the poorer authorities". Even then there was "no agreement how this could be done".[36]

However, once consensus over the aim of the formula review had been established the committee's consideration of detailed revision also began to converge with that of

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35. ibid, minute of meeting between Hughes and Arthur Collins, 30.3.1936.
36. ibid, minute of meeting between Gilbert and Hughes, 23.6.1936.

the Ministry. This was cemented by Collins' decision to follow Ministry advice and include special representatives of the necessitous areas on the financial advisers committee to ensure that their needs were properly known.[37] Such a decision had the further advantage, as far as the Ministry was concerned, of lending a pluralist legitimacy to whatever conclusions the committee jointly reached. By June 1936 the committee had concluded tentatively that "it would be an improvement in the formula if the weighting factors, or some of them, were strengthened". The principal formula factors under consideration were unemployment, rateable value and the number of children under five.[38]

It would be a mistake, however, to suggest that the members of the financial advisers committee acted corporately above the interests of the local authority associations which they represented. County council antipathy to greater weighting for unemployment was well aired on the committee, and there were various different stresses placed by individual members on the variation in formula weighting that was needed.[39] However, Hughes, at the Ministry of Health, was adamant that the committee should be kept together and as its ideas evolved be encouraged to come to a unanimous set of recommendations.

In September 1936 Hughes put the provisional proposals of

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37. PRO HLG 52/256, Hughes to Sir George Chrystal, 25.7.1936.
38. PRO HLG 52/255, minute of meeting between Hughes and other Ministry officials with Arthur Collins and his assistant, Mr Hills, 25.6.1936.
39. See, for instance, PRO HLG 52/256, Hughes to Chrystal, 25.7.1936.

the accountant-general's division, which had been worked up in the preceding twelve months, to the committee in the hope that it could crystallise committee thinking.[40]

The result was that the committee responded favourably to the proposals for greater weighting in the formula for unemployment and population sparsity, each respectively giving greater assistance to county borough and county council interests, but rejected Ministry proposals for superweighting for low rateable value, the inclusion of children between five and fourteen in elementary education in the child factor as well as rejecting the suggestion of a new factor of declining population. Acceptance of the committee's views meant that the Ministry proposals for improving the redistributive facility of the block grant formula, limited in themselves, would be further watered down. Yet the committee's response offered the possibility of agreement on revision which went some way towards improving the block grant formula. In October 1936 Hughes suggested to Collins that the Ministry would abandon "the three parts of the formula revision to which they must object" in return for agreement on the change in formula weighting for unemployment and population sparsity.[41] The committee duly complied and made unanimous recommendations along these lines to the various local authority associations.[42]

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40. ibid, Hughes to Gilbert, 10.10.1936.
41. ibid, Hughes to collins, 7.10.1936.
42. ibid, Sir Kingsley Wood to Neville Chamberlain, 28.10.1936.

The local authority associations generally endorsed the recommendations of Collins' committee; any residual opposition from more prosperous authorities being undermined by the fact that the overall large increase in the aggregate sum of the block grant in the third period meant that there would be very few losers even if the grant did target grant more to poorer authorities. A united local government view on formula revision was attained, which embraced the retention of population as the basis of the formula, advocated extra weighting in the formula for two factors which would assist needy local authorities, and eschewed the addition of any new factor. Only the CCA took a maverick line in advocating a variation of all the factors in the formula. However, their proposals made comparatively little difference to the results gained from the consensus view, which ultimately based upon a compromise of the Ministry of Health proposals came to be known as test D3 modified. The CCA position, therefore, was ignored.

With some proviso, therefore, Ministry of Health officials were highly successful in using the committee of financial advisers to secure agreement to the improvement of the block grant formula as a redistributive mechanism along the lines which they originally intended in 1935. In December 1936 the Minister of Health, Sir Kingsley Wood, was able to inform Neville Chamberlain that the block grant would be

considerably more favourable to the poorer local authorities in the third period than in the second.[43]

Any case for the revised block grant formula more successfully benefiting poorer authorities relative to their needs in the more favourable economic and social conditions of the late 1930s is, however, still seriously open to question. The county of Glamorgan was a good example of where the additions in income were welcome in helping to fund the cost of the increase in expenditure on public assistance but compounded disillusionment that the block grant would not erode the fundamental inequalities in local authority income which left their services otherwise deficient compared to other authorities. Sir William Jenkins informed the Ministry in February 1937 that 1s 5d of the 2s rate per head additional subsidy that the block grant would provide for the authority in the third block grant period would immediately go on paying for the natural increase in the cost of public assistance between 1936/1937 and 1937/1938. Therefore, more or less, "what they gained under the new formula would completely disappear and they would have to continue to restrict their social services".[44]

Equally, it would be hard to suggest that the revision of the formula in 1937 bode well for the block grant

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43. ibid
44. PRO HLG 52/257: Investigation of exchequer grants under Section 110 of the 1929 Local Government Act, Jan-March 1937, early 1938. Minute of meeting with deputation from South Wales and Monmouthshire necessitous areas conference, 25.2.1937.

being a successful mechanism for redistribution in the long-term. As in 1930, in the absence of uniform rating and valuation, the revised formula weightings only made the formula a rough index of need for the coming period. In the mid-1930s the Ministry of Health could have pursued rating and valuation reform again with more profit. Perhaps with this in mind the 1937 Local Government (Financial Provisions) Act stipulated that there would be a further review of the block grant formula before the end of the third grant period.[45] Without a timeless and automatic mechanism within the block grant formula for achieving its redistributive aims the Ministry of Health left itself open to continued controversy in inter-governmental relations over the working of the block grant as well as the prospect of only further incremental adjustments towards the greater state assistance of local government on the basis of local need.

The implementation of the block grant as a means of equalising the financial resources of local authorities, and thus providing the basis for greater uniformity in the ability of authorities to meet the service needs which they faced, did not therefore, run aground on the unforecastable effects of the recession. Rather, it proved to be during the 1930s largely the failure that one could have predicted in 1929. The block grant formula operated on only a quarter of the grant for much of the decade, and whilst some of the beneficial impact

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45. Parl.Deb., 1936-37, 320, cols.2012-2119.

of the operation of the formula was undermined by the recession in the early 1930s, its inherent weaknesses, nevertheless, came home to roost fully in the inequitable grant distribution it produced in the second grant period. Any chance that the block grant review at the end of the second period might provide the opportunity for the correction of the deal of 1929 was thwarted by the continuation of a gradualist approach by the Ministry of Health, conditioned as it was by the public expenditure and self-interested concerns of the bureaucratic elite. That the block grant review would fail to erode the essential income inequalities existing between local authorities was guaranteed by the Ministry's continued respect for the interests of more prosperous authorities who had done well under the percentage grant system before 1929, and which were entrenched in the local authority associations. An incremental adjustment towards benefiting the poorer areas of the country, which, nevertheless, failed to meet their real needs, was portrayed as another great leap forward which met with the approval of all of local government. The reality of the situation was covered over by the Ministry's skilful management of inter-governmental relations in much the same way as in 1929. The block grant in terms of the equalisation of local authority finances indeed remained at the end of the 1930s akin to placing a plaster over a gaping wound.

3. THE BLOCK GRANT AND FURTHER REFORM

During the 1930s, therefore, the block grant in terms of both of its original aims to act as an aggregate grant aid control and a mechanism for grant aid related to need largely failed. As was shown in chapter two, the block grant principle was a limited option with respect to both aims. A consideration of the impact of the experience of implementation on the making of future policy shows a disinclination both amongst bureaucrats and politicians to depart from the block grant option to realise these aims. Nor, however, did they continue to think of the block grant option in the same terms as in the 1920s. They realised that the manner in which the block grant had been introduced in 1929 was not a model for future reform. Rather, they adopted the attitude that lessons could be learned and the block grant principle be used in a revised form as the basis for future reform. Such lessons were learned more quickly with regard to the operation of a block grant as a grant aid control than they were in relation to its redistributive capacity.

The comparative failure of the block grant as a negative grant aid control during the 1930s aroused heated debate amongst politicians. During the Parliamentary debates over the introduction of the block grant for the second period in 1933 many government supporters in Parliament advocated the reduction of the additional sum, and the abolition of the minimum proportion formula, which automatically set its level.

Some, such as Eustace Percy, made the point that it was sheer folly if the government wanted to limit public expenditure to carry on fixing the block grant for years ahead when at that point further falls in local authority spending and grant aid outside the block grant could be reasonably assumed. It constituted the waving of budgetary control in much the same way as percentage grants had done in the 1920s.[46]

The government, whilst undoubtedly wishing to do otherwise, defended the block grant reform. The principal motivation for this was the undesirability of alienating local government. The latter obviously benefited greatly from the additional subsidy that the block grant constituted and in the 1932 Ray Report had called for the further block granting of other local authority aided services.[47] They would oppose any revision of the existing block grant provisions in respect of aggregate aid. Such opposition was undesirable if the goodwill of local government was to be retained in the implementation of the service provisions of the 1929 local Government Act. At the same time the government faced legitimate claims that a reduction of the block grant would further push local authorities in to financial crisis. In any case, any attempt to revise the block grant would have necessitated legislation, which in this context would have proved massively controversial not only with local government but also

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46. Parl.Deb., 1932-33, 274, cols.1617-1681.
47. Report of the (Ray) Committee on Local Expenditure (cmd.4200) PP (1932).

with members on all sides of the House of Commons. Nor was a Minister of Health of the knowledge or ability of Neville Chamberlain on hand to construct and carry such legislation. In 1937, even though calls for revision, were made they were more muted, and at that point more pressing concerns engaged politicians.

The Treasury, whilst desiring revision, had to grin and bear the block grant as it had been created in 1929. However, by 1933 Treasury officials had made certain key decisions about block granting of other aided local authority services both in the short and long-term. The key forum for debate was an inter-departmental conference on block grants. Here, officials became aware of the disparate views on the block grant question. On the one hand they were faced with the Parliamentary suggestions which would make future block grant reforms tougher and more reliable as grant aid controls. On the other hand, they were faced with the exhortations of the local authority associations and the Ray Committee to extend the present form of block grant to other services, and by Ministry of Health officials, who were making optimistic noises about the beneficial effect of the block grant on poorer authorities. Treasury sympathies were to the former as the block grant's role as a grant aid control was manifestly a higher priority than its role as an equaliser of local authority finances.

Treasury officials now realised that the bribe of £5 million to local authorities in the 1929 Act, thought originally to be an insignificant short-term loss against

long-term gains, had indeed been a very significant concession. For such a bribe could continue in the long-term to wipe out the grant aid savings to be made from having a block grant instead of specific percentage grants. This realisation influenced Treasury thinking at the conference in relation to the block granting of education. Rather than being actively in favour of block granting education, as Rhodes suggests, C.L.Stocks, an assistant secretary at the Treasury, argued that "at present we shall lose by blocking, despite the strong arguments in favour of block grants generally....in starting a "block" there would have to be a bribe of £5 million for education alone (as the percentage grant is now down to 48 and the LEAs are demanding more), and this would simply give away at the start all the savings we expect to acquire laboriously in the next fifteen years...There will probably be insufficient set-off from local economies due to blocking, because an age of economy probably lies ahead anyhow". He considered that the block granting of education could be achieved if it was done as part of a general block granting of all remaining specific grant-aided local authority services. However, he considered that "unless, therefore, there is a lot of "fat" on road and police grants which will secure us large savings there under block, in general, we shall lose by blocking, and that is why local authorities favour blocking mainly". In the main he was not optimistic.[48]

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48. PRO T 161/632/S.39586: Block grants, 1926-1934.

As a result of Stocks' arguments, far from advocating the rapid expansion of the block grant principle to other exchequer-aided local authority services, the Treasury in 1933 vetoed any further block granting until such time as there was a large increase in the expenditure on specific grant aided services which would make the initial costs of block granting worthwhile. Such circumstances did not arise until after the Second World War, and Treasury considerations allied to continued objections by individual departments to their services going on non-specific grant aid, meant that no significant addition to the local authority grant aided services included under the block grant, was made until 1960. It was at this point that education finally came under the purview of a block grant.[49]

During the War itself further consideration of the experience of the block grant in the 1930s led the Treasury to consider also the abandonment of the principle of fixing future block grants for periods of years. The Treasury wished to retain the principle of setting the aggregate level of grant aid centrally but also wished to incorporate the flexibility of the percentage grant in reflecting trends in local authority expenditure. The ideal compromise was to fix future central grants again on an annual basis.[50] Hence, whilst, the 1929 Act may have established the principle

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C.L.Stocks to Ernest Strohmenger, 19.7.1933.
49. See K.B.Smellie, A History of Local Government (4th edition 1968), p.142.
50. See PRO HLG 52/1479: Block grants review 1947.

of block grants in central-local financial relations, the experience of the block grant in the 1930s helped to establish a more cautious approach to the adoption of the principle, and a revision of the principle of fixity which was embraced first in the exchequer equalisation grant from 1948.

Recognition within government of the inherent weaknesses of the block grant as a means of realising the greater equalisation of local authority finances was not made until towards the end of the Second World War. The intervention of the War had meant that the third block grant period was extended until 1945 without the conduct of a further review of the block grant formula. The extension of a deficient system had made its failure all the more apparent. In November 1945 even the senior Treasury official, B.W.Gilbert, was forced to recognise "the inescapable fact...that some local authorities in this country are poor and some are rich". Gilbert now took the view that it would be "necessary to think of assistance much less in terms of standard grants for rich and poor alike and much more in terms of concentrating our assistance on the poorer areas with the greater need". Incoming Labour ministers took a more trenchant approach. Arthur Greenwood, who had been Minister of Health in the Labour Government of 1929-1931, told Hugh Dalton, the Chancellor of the Exchequer, in November 1945 that they now approached "a situation in which it is becoming increasingly difficult to redress the disparities between the richer and poorer areas except by

giving the poorer areas what is virtually a 100% grant".[51] The review of block grants in 1947 produced further condemnation of the block grant formula for weighted population and its failure to make up for the more ideal indicator of need of rateable value per head based upon a uniform system of assessment.[52]

The result of this new debate, free from the self-restricting approach to the implementation of the block grant during the 1930s, was to point towards a new grant, the exchequer equalisation grant, created by the 1948 Local Government Act which was based more upon the specific objective of moving towards local authority income equalisation and which had at is heart a reliable indicator of local need. Consequently, the exchequer equalisation grant was based upon two significant revisions of the principles of the block grant of the 1929 Act. First, it took rateable value as its basis for redistribution. A standard rateable value was to be calculated for each local authority by multiplying the weighted population for the authority area by the average rateable value per head of the weighted population for England and Wales. Those authorities which had actual rateable values beneath their standard rateable values gained targeted grant. Chester, in particular, describes the greater success with which this method of grant distribution narrowed the range of rates levied by

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51. PRO T 161/1200/S.53198: Division of burden of local expenditure between local rate and exchequer funds, papers, November 1945. Gilbert to Rampton, 14.11.1945 and Greenwood to Dalton, 15.11.1945.
52. PRO HLG 52/1479: Block grants review 1947.

different local authorities, in sharp contrast to the achievements made under the block grant. Secondly, in taking rateable value as the basis for grant distribution, the exchequer equalisation grant assumed more reliable figures for rateable value. From this the logical step was then taken to place responsibility for rating and valuation, also as a result of the 1948 Act, under the auspices of the Board of Inland Revenue.[53]

These developments echoed what had been originally envisaged as necessary for the practical realisation of the block grant reform's redistributive aims in the period immediately after the First World War by the Ministry of Health's then accountant-general, Ernest Strohmenger. Such comparison only serves to underline the fact that the intervening period, as in so many other spheres of public policy, may be characterised as lost years even in terms of the aims of government, constrained as they were by the overriding objectives of the bureaucratic and political elites to preserve and allow the preservation of the pre-First World War world for as long as possible. What implications the implementation of the exchequer grant reform as well as the poor law reform of 1929 had for local authority health care and the future evolution of public health care policy is the concern of the next chapter.

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53. D.N.Chester, Central and Local Government, Financial and Administrative Relations (1951), pp.270-278.

CHAPTER SIX

THE IMPLEMENTATION OF LOCAL HEALTH CARE REFORM

The 1929 Local Government Act changed the form of grant aid for local authority health care, transferred the poor law health services to local authorities, and bid local authorities to secure co-ordination of local provision also by co-operation with the voluntary hospitals. Previous analyses of the implementation of these aspects of the 1929 Act have suggested that to a greater or lesser extent they failed in their aim to secure significantly more even development of services between authorities, as well as having only highly qualified success in securing greater co- ordination, either through the appropriation of poor law health services under public health acts or through co-operation with the voluntary hospitals. It is important to note, however, that the extent to which different individual local authority services were deficient is still contested. In addition, it remains unclear as to whether the principal cause of deficiency, where it did exist, was poor resources or an inherent deficiency in local approaches to health provision.[1] An apologia for poor resourcing may be found in the view that the potentially helpful effects of the block grant were eroded by the effects of the recession, and for poor local approaches in a consideration of the many mitigating factors influencing local health provision and implementation of the 1929 Act

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1. See chapter one.

in the 1930s. This chapter begins with a reconsideration of the nature and causes of uneven local health service development, on the basis of the previous paucity of research. In particular, analyses have commonly been made without reference to the results of the local authority health surveys carried out by the Ministry of Health under the 1929 Act.

The chapter then re-assesses the views that central control was either impotent or generally inappropriate in relation to influencing local policies. This reassessment is made with reference to the results of the health surveys and the central-local relations over health provision which were conducted in relation to the health survey procedure. Finally, the chapter reconsiders the orthodox assumption that, however implementation and local health provision in the 1930s may be portrayed, it in no way disinclined the Ministry of Health, and indeed much of central government, to continue to use the local government option as a focus for further extensions of public health care until the very late stages of planning for the National Health Service. This reconsideration is made in the light of the fact that previous analyses of the planning of future reform have generally focused on high level strategic planning within the Ministry of Health rather than reactions to the 1929 Act. By these approaches to analysis the chapter hopefully provides a more global picture of the nature and causes of differences in local provision, and the nature of central-local relations, as

well as eroding some of the assumptions concerning a linear progression of local authorities as health providers, only upset by the medical politics which transformed the National Health Service at the end of the Second World War.

1. THE HEALTH SURVEYS AND UNEVEN DEVELOPMENT

It must be clearly noted, first, that at an aggregate level the grant reform in 1929 had no adverse implications for local authority health expenditures. Figure 3 demonstrates how at current prices health expenditure rose during the 1930s both in absolute terms and as a proportion of total local authority revenue expenditure. Given this, the figures showing the steady rise in the value of total revenue expenditure in real terms indicate that the real value of local authority health expenditure was also rising , and during the 1930s at a faster rate than during the 1920s. Figure 4 demonstrates how the rise in total local health expenditures during the 1930s is primarily accounted for by the growth in expenditure on municipal hospitals, but also shows that for three key local health services that had previously enjoyed percentage grant aid, the grant reform caused no adverse effect upon expenditure.

Unfortunately, aggregate expenditure patterns are no guide to the nature of local health expenditures in individual local authorities and the standards of service provided. That there was uneven development is equally

not to be doubted. What is presented here is a discussion of uneven development in health service development and standards, and its causes, through evidence provided by the Ministry of Health's own considerations. Such evidence requires some introduction.

In the place of detailed checking of individual items of grant aided expenditure, which accompanied percentage grants, from 1930 the Ministry of Health instituted more general surveys, to accompany the more general form of grant-aid. The surveys represented a major supplement to

Figure 3 Total Local Authority Revenue Expenditure and Local Authority Health Expenditure, 1920/1921-1936/1937

YEAR	TOTAL LA REV EXPEN (1975 PRICES) £m (a)	TOTAL LA REV EXPEN (CURRENT PRICES) £m (b)	TOTAL LA HEALTH EXPEN (CURRENT PRICES) £m (c)	(c) as % of (b)
1920/21	2,165.5	343.2	36.1	10.52
1921/22	2,878.5	365.0	36.2	9.91
1922/23	2,883.4	346.7	32.1	9.26
1923/24	2,844.0	343.3	31.6	9.20
1924/25	2,910.9	354.9	32.8	9.24
1925/26	2,900.1	373.1	34.1	9.14
1926/27	3,475.3	402.2	35.6	8.85
1927/28	3,440.7	402.6	36.3	9.01
1928/29	3,584.9	414.7	37.4	9.02
1929/30	3,758.2	423.7	39.0	9.20
1930/31	4,034.9	432.7	42.4	9.80
1931/32	4,143.3	435.0	45.1	10.37
1932/33	4,201.7	430.3	46.1	10.71
1933/34	4,212.4	433.2	47.9	11.06
1934/35	4,396.8	454.8	49.7	10.93
1935/36	4,460.1	470.9	52.4	11.13
1936/37	4,405.5	484.6	55.5	11.45

Source, C.D.Foster, R.A.Jackman and M.Perlman, Local Government Finance in a Unitary State (1980), pp.103-108, Ministry of Health Annual Reports, 1920/21-1934/35, and Local Government Financial Statistics, 1934-1937

Figure 4 Total Local Authority Revenue Expenditure On Selected Health Services, 1929/30-1938/39 at Current Prices

YEAR	TUBERCULOSIS (£m)	VENEREAL DISEASES (£m)	M&C WELFARE (£m)	GENERAL HOSPITALS (£m)
1929/30	3.339	0.411	2.403	-
1930/31	3.579	0.417	2.855	1.259
1931/32	3.601	0.439	3.013	3.245
1932/33	3.614	0.434	3.052	4.084
1933/34	3.699	0.436	3.077	4.660
1934/35	3.827	0.440	3.221	4.971
1935/36	4.016	0.449	3.505	5.885
1936/37	4.162	0.468	3.731	7.130
1937/38	4.475	0.472	4.977	8.514
1938/39	4.700	0.486	5.716	9.993

Source, Annual Local Taxation Returns and PRO T 161/632/S.39586

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the reports already received from county and county borough medical officers of health, and, indeed, allowed the construction of a comprehensive picture of every local authority's health service and a comparison thereof by a central government department for the first time. The surveys were begun in 1930 and it was intended that they be completed by 1933 so as to provide the comparative basis necessary for evaluating which, if any, local authorities should have their block grant apportionments withheld or reduced. In the event such a deadline became impossible to meet.

Dr Macewen, a senior official in the public health division, was placed in charge of the surveys. Each survey was conducted by one inspector over a period lasting at least two weeks and then written up in report form, generally with a special section on maternity and

child welfare researched and written by another inspector. The inspectors looked to describe and evaluate the main themes of a local authority's services in the context of local need and resources.[2] On the whole inspectors were received with great enthusiasm by local public health officials and furnished with all available data and information. Often local authorities asked for early survey in order to gain informed guidance in relation to the implementation of the transfer of former guardian services and future health planning. In this context the Ministry sought, in particular, to build up expertise amongst its inspectors in the field of hospital planning and administration so as to facilitate expert inspection and advice. The sheer number of local authorities providing health services meant that surveys were limited to county and county borough councils. Ministry officials decided to place their reliance on the county councils to draw their attention to any second tier local authorities, responsible for maternity and child welfare provision, who were considered deficient in any way. Even then the time consuming nature of the surveys meant that they were not completed until towards the end of 1934.[3] A compilation of the health survey results was, however, then possible.

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2. PRO MH 55/10: Papers relating to public health surveys. Memorandum for guidance of inspectors, written by Sir Arthur Robinson, 24.6. 1930.
3. PRO MH 55/17: Progress and scope of public health surveys, 1931-1935. J.C.Wrigley to Mr Maclachlan, 17.4.1931; Mr Maclachlan to Sir George Newman, 30.4.1931; Mr Maclachlan to Sir George Newman and Sir Arthur Robinson, 26.10.1931.

It revealed the nature of uneven development and some of the causes of deficiency.

Of course, the surveys showed up many notable local successes. Especially where there had been good resources, and health provision had been a high priority before 1929, the extra income from the block grant at least in part was directed towards the improvement of that provision. This was the case, for example, with Bristol, which became one of the leaders in local health provision nationwide by the mid 1930s.[4] Further, the surveys also revealed good provision in local authorities which were basically hampered by poor resources. Middlesbrough and Tynemouth, for example, are conspicuous by their absence from major criticism. In these areas one may perceive that the block grant had at least a partially beneficial effect, or that local preferences were made that benefited health provision only at the expense of other services. Nevertheless, such examples suggested that the attainment of good health provision, at least in the eyes of Ministry of Health inspectors, was not simply a function of local resources.

Despite the successes there were, however, many notable failures. In sum the health surveys revealed that in England alone 22 out of 49 county councils and 23 out of 79 county borough councils were sufficiently deficient to require re-survey and the application of central pressure for improvement. This was over 1/3 of

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4. PRO MH 66/487: Ministry of Health public health survey of Bristol county borough, 1932.

local health authorities. What is particularly striking from the survey files is that in many cases this sort of comprehensive knowledge of the scale of deficiencies in local authority provision was being gained for the first time, and findings were very often at odds with the encouraging tones of many local medical officers of healths' reports on which Ministry officials had previously largely relied. Such evidence bears out quite strongly a more pessimistic view of local health care in the 1930s.[5]

The summary conclusions of causation of deficiency derived from the Ministry health surveys, and expressed in their own words, are shown in figures 5 and 6. They reveal the perception of poor standards of overall provision in a large proportion of the authorities listed for re-survey. Moreover, only in two local authorities was the basic resource problem recognised as the principal reason for poor standards of overall provision. These were South Shields and Gateshead, which were listed sympathetically in April 1934 as "two depressed areas where conditions are very difficult and where we might with advantage keep in touch".[6] However, even then, a distinction was made between the two authorities. In his report on South Shields in September 1931 Dr Donaldson, the inspector, suggested that the council was "somewhat difficult to deal with as they are apt to confuse

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5. See PRO MH 55/16: Progress of public health survey correspondence, 1931-1935.
6. ibid, memorandum by J.C.Wrigley, 28.4.1934.

parsimony with economy".[7] Comparison by Ministry officials of South Shields' performance with Gateshead, which they considered to be of equivalent size and resources, suggested that "there can be little doubt that Gateshead makes a much better show than South Shields. One gets the impression from the Gateshead survey report that the council are doing their best, whereas the South Shields council seem reluctant to put their health services in order".[8] This view of South Shields was indicative of the much more common assessment that the origins of deficiencies in local health provision were to be found primarily in the unhelpful attitude of the local authorities themselves.

Inspectors reports and the office consideration of their contents all too often concluded that local authorities had little interest in developing health services and the new freedom to use block grant aid in other ways merely confirmed them in their reactionary attitudes. Most prominent amongst these were the county councils of Yorkshire, North Riding, Hereford and Bedfordshire, the latter of which was listed as "another authority which will always give the minimum response", especially on maternity and child welfare.[9] Huntingdonshire, Derbyshire, Lincolnshire (Holland), Great Yarmouth, Burton-upon- Trent, and to a slightly lesser extent Leicestershire, Staffordshire, Gloucester-

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7. PRO MH 66/890: Ministry of Health public health survey of South Shields county borough, report by Dr Donaldson, p.5.
8. ibid, D.C.Ward to J.C.Wrigley, 7.11.1931.
9. PRO MH 55/16, memorandum by J.C.Wrigley, 28.4.1934.

Figure 5 County Councils Designated For Health Services Re-Survey and Results, 1931-1935

DEFICIENT COUNTIES	REASON	RESULT
Cornwall	Backward	No progress
Yorks, North Riding	Reactionary	No progress
Herefordshire	Difficult	Small progress
Huntingdonshire	Backward	Clerk good, Council do little
Bedfordshire	Reactionary	No progress partic, M&CW
Derbyshire	Reactionary	No progress, poor on hospital prov
Dorset	Lack of skill	No progress
Devonshire	? Suspicious	Little progress
Berkshire	Slow mover	Moving on right lines. New MedOH
Shropshire	Backward	
Lincs, Holland	Reactionary. Active MedOH given up and left	
Somerset	Unorthodox M&CW Little hospital appropriation	
Leicestershire	Deficient	Postponed action on finan grounds
Southampton	No interest in hospital approp. Poor TB	
Staffordshire	Deficient	
Warwickshire	Resented central interference. Anti-hospital appropriation	
Gloucestershire	Deficient	New MedOH offers hope
Buckinghamshire	Low spending	Ministry ignored
Durham	Bad institutional provision	
Essex	No hospital plan	
Oxfordshire	Possibly bad	
Worcestershire	Possibly bad	

Source, PRO MH 55/16, Progress of Public Health correspondence 1931-1935

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Figure 6 County Boroughs Designated For Health Services Re-Survey and Results, 1931-1935

DEFICIENT C.BOROUGHS		REASON RESULT
West Hartlepool	Reactionary	Do little
Great Yarmouth	Reactionary	Do little
Burton-upon-Trent	2nd rate LA esp on hosps	Do little
Sunderland	TB & M&CW bad	
South Shields	Depressed	
Gateshead	Depressed	
Stoke-on-Trent	Well developed, but poor co-ord	
Wigan	Poor M&CW,Hosp	
Bournemouth	Poor TB	
Exeter	Blind welfare bad	Still bad
Worcester	Minor criticisms	
Oldham	Poor hosp admin	
Preston	Good, but poor MedOH	
Blackburn	Bad on hosp approp	
Lincoln	V.bad hosps	Not moving
Blackpool	-	Improves
Darlington	Re-org of services bad	
Derby	Okay, but?	Watch new MedOH
Grimsby	Unsatisfactory	Big improvement
Oxford	Bad hosp prov	"Much talk but nothing concrete has emerged"
West Bromwich	Poor sewerage and sewage disposal	Progress
Doncaster	Reactionary	Nothing
Plymouth	Favourable survey, but restriction of services since, especially hospitals	

Source, PRO MH 55/16 Progress of Public Health Correspondence 1931-1935

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shire, Oxford and Worcester were all relatively well off local authorities which also simply opted not to provide good all-round services. Some of the poorer authorities who faced a greater demand on their health services, moreover, were perceived by the Ministry as exhibiting a

distinct lack of enthusiasm for health provision, thus ensuring generally poor provision. These included Cornwall, Sunderland, West Hartlepool, Doncaster and Grimsby. The Ministry perceived these authorities as not even using grant aid gain made through the block grant on the improvement of health provision. Indeed, it was suggested that some of these authorities used the new freedom to spend grant aid as they pleased to arrest even existing development.[10]

On the basis of the Ministry's own judgment of the reasons for local policy failure lack of financial resources barely ranked as a reason let alone one of primary importance. The principal reason for general failure where it occurred was perceived as being that of a reactionary and backward approach to health care, irrespective of whether the local authority was well resourced or not. Ministry of Health assessments of the causes of general local deficiency should, however, be treated with some scepticism. Webster, Macnicol and Mayhew have already shown how the Ministry was inclined to disbelieve, ignore or suppress evidence which suggested that health standards were low in any particular area because of inadequate public resourcing, for the reason that if they were to accept such evidence it would imply a much greater role for state

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10. See, for example, PRO MH 66/988: West Hartlepool county borough, public health survey under 1929 Local Government Act, 1931. Report by Dr Donaldson, March 1931, introduction; PRO MH 66/991: West Hartlepool public health survey correspondence, 1931-1934. Memorandum by Mr Infield, 23.2.1932.

responsibility. Such acceptance would have been in contradiction with the Ministry of Health's compliance in the 1930s with the bureaucratic and governmental imperative to keep public expenditure down.[11]

Similarly, therefore, it may be argued that Ministry officials refused to accept in internal discussion that any of the local authorities could not provide health services at even the minimum standards laid down by the Ministry because of inadequate resources for the reason that it would have laid the basis for an argument for an increased subsidy to those areas, which would have meant an increase in the block grant or a revision of its formula more strongly in the favour of poorer areas. As was shown in the last chapter the Ministry could not expect the former and were not inclined to promote the latter. It was much easier and less controversial, then, to simply describe poorer authorities who were generally deficient as backward or reactionary.

There are obvious difficulties in ascertaining whether a local authority in a necessitous area should have been more properly defined as backward in its approach to provision or inadequately resourced. Certainly the evidence that poorer authorities were little helped by the block grant during the 1930s lends credence to the view that such authorities as South Shields and Gateshead

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11. C.Webster, 'Healthy or Hungry Thirties', History Workshop Journal, no.13, 1982, pp.110-129; J.Macnicol, The Movement for Family Allowances, 1918-1945 (1980), chapter five; M.Mayhew, 'The 1930s Nutrition Controversy', Journal of Contemporary History, vol.23, no. 3, July 1988, pp.445-464.

were found deficient for the root reason of inadequate resources, and the discussion in the previous chapter suggests that an apologia for the block grant in this respect is inappropriate. In addition, health survey reports showed scant regard for the wider service demands placed upon local authorities in necessitous areas, particularly in regard to public assistance. They were inclined to review health services in isolation. Consequently, the case that such authorities were wrongly characterised as being merely reactionary or backward is strengthened. Yet, the important conclusion to be drawn from the results of the surveys is that there were many authorities found generally deficient who did not suffer inadequate resourcing. This suggests that the exercise of local autonomy on block grant aid was at least as important a factor as low resources in determining poor provision.

The exercise of local autonomy against the development of public health services should not, perhaps, always be seen in critical terms. West Hartlepool was a good example of an authority which claimed its relatively low prioritisation of health service development was offset by its emphasis on a housing programme as a better long-term policy to improve living conditions and so erode the incidence of disease. It laid the stress on a preventative rather than a curative approach to health care.[12] However, West Hartlepool's case, as did that of

12. PRO MH 66/988, report of conference of north-east local authorities to discuss general shortage of residential accommodation for tuberculosis patients, p.4.

others, as an authority committed to public provision fell down in the context of consideration of the rate policies of local authorities during the 1930s.

On the one hand, it is entirely proper to suggest that local authorities were merely complying with central direction when they stabilised or reduced rates in the early 1930 (See figure 7). Indeed, there was almost universal local authority compliance with the national economy circular of 1931. It is important to remember in this respect that the vast majority of local authorities were run by Conservative-minded political alliances, which had the same political commitment to economy as government at a national level. Only in a handful of local authorities did the rate actually go up in the early 1930s. In this context it was highly logical for local authorities to use some or all of the extra money coming in through the block grant to relieve the rate further. The Ministry of Health had no logical grounds for chiding them for doing so for it had issued the economy circular. The call for economy and for health service expansion at the same time were in essence contradictory.[13]

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13. PRO HLG 52/1008: National economy, social health services policy, particularly, J.C.Wrigley to Mr Maclachlan, 18.11.1931 and a copy of "A Vicious Circle", in Public Assistance Journal and Health and Hospital Review, 23.12.1932.

Figure 7 Annual Average Rate for England and Wales, Selected Years 1913/1914-1938/1939

YEAR	AVERAGE RATE
1913/1914	6s 9d
1919/1920	9s 7d
1927/1928	12s 10d
1928/1929	12s 5d
1929/1930	11s 7d
1930/1931	11s 8d
1931/1932	11s 2d
1932/1933	10s 10d
1933/1934	10s 10d
1934/1935	10s 10d
1935/1936	11s 3d
1936/1937	11s 7d
1937/1938	11s 8d
1938/1939	12s 4d

Source, Summary of Local Government Financial Statistics, 1936-1937 and Rates and Rateable Values in England and Wales, 1938-1939.

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On the other hand, rate statistics and the health surveys suggest that some local authorities, notably county councils, had a much longer-term commitment to keeping the rate down irrespective of the state of the local or national economy. In the counties there was often an undeveloped sense of the council as a community focus for provision for those in need. The focus, if it existed at all, was provided by voluntary associations, and the county council was intended to intervene in people's lives as little as possible. Rate limitation was also, of course, often an election winner. The shortcomings and realities of local politics were, therefore, principally responsible for a long-term reactionary attitude against improved social provision.

Similar situations could be perceived in urban areas. In nine of the county boroughs considered sufficiently deficient to require re-survey a policy of rate reduction in the early 1930s was followed by stabilisation at the lower level throughout the rest of the 1930s. These included West Hartlepool, as well as Great Yarmouth, Plymouth, Burton-Upon-Trent, Gateshead, Wigan, Darlington, Derby and Doncaster.[14] Gateshead's rate policy, it should be noted, led to a waning of Ministry sympathy in this case as well as that of South Shields during the mid-late 1930s.

It may be argued, therefore, that the block grant was doubly malign in its impact upon local authority health care. Not only did the exercise in grant redistribution fail to help poorer local authorities sufficiently to improve their health services to standards acceptable to the Ministry of Health, but also in granting local authorities greater local autonomy in its expenditure the block grant facilitated the entrenchment of anti- public health policies and the subsidisation of the rate instead. This latter point could be seen further in microcosm in relation to those authorities listed for re-survey on the grounds of deficiency in a particular service.

Here again there were a large number of authorities found culpable. Somerset, West Bromwich and Wigan, for example, were very poor on provision of maternity and

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14. This summary is based upon rate statistics collected from local taxation returns and reports in the Municipal Review (1928-1939).

child welfare services; Southampton and Bournemouth on tuberculosis; Lincoln, Oxford and Wigan again on hospital provision; Exeter on the provision of blind welfare.[15] Many of the local authorities listed in figures 3 and 4 with the addition of a further six county councils and twenty-four county borough councils were also guilty of having conducted very few relations with the voluntary hospitals in their areas by late 1934.[16] The reasons for such deficiencies were many and varied. The reasons for non-appropriation of Poor Law infirmaries as hospitals and lack of co-ordination with voluntary hospitals, and the factors mitigating against the appropriateness of criticising local approaches to provision have already been discussed extensively by Abel-Smith. With regard to other specific deficiencies, however, local authorities, on the basis of Ministry evidence, were found to have been wilfully negligent. Local ignorance of health problems and means of solution appears to have been a major reason for deficiency, especially with regard to maternity and child welfare provision. Reasons for deficiency could be highly idiosyncratic. Bournemouth County Borough Council, for instance, was loath to provide good facilities for the tuberculous for it feared , in view of the town's position and history, that they

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15. PRO MH 55/16, memorandum by J.C Wrigley, 28.4.1934.
16. PRO MH 55/22: Progress of public health surveys-co-operation with voluntary hospitals, unsigned minute, November 1934.

might attract more prospective tuberculosis patients to the area.[17]

Otherwise deficiencies in provision arose as a result of wasteful inefficiency on the part of the local medical officer of health. This was especially the case in Dorset, Gloucestershire and Preston where Ministry inspectors held the local medical officers of health mainly responsible for the poor use of what money their departments were allocated by Council.[18] This should be seen, however, as also a product of local choice. A low council priority for health provision would habitually mean a low salary for the medical officer of health. It was hardly surprising then that the officers they appointed were not greatly experienced or well qualified. Slack council practices of appointing on the basis of who you know rather than what you know were also to blame. Although this did work to a local authority's advantage in certain places, such as Bristol, where a medical officer of health, with very little formal qualifications, was appointed as a result of his friendship with the chairman of the health committee, and went on to achieve great success.[19]

More generally, local authorities were found to be unenthusiastic in the discharge of their public health responsibilities. This was found in its most acute form

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17. PRO MH 66/473: Bournemouth county borough, public health survey, report by Dr Donaldson, April 1932, p.10.
18. PRO MH 55/16, memorandum by J.C.Wrigley, 28.4.1934.
19. PRO MH 66/487: Ministry of Health public health survey of Bristol county borough, 1932, report by Dr Allan C.Parsons, pp.160-170.

in relation to provision for the mentally deficient. Ministry inspectors found that it was an unpopular service with many local public health committees and officials. They found the work unpalatable and left to their own devices were apt to assume responsibility as little as possible. Sir Lawrence Brock of the Board of Control, which was responsible for mental deficiency, informed Arthur Robinson in October 1931, for instance, that "my trouble with the councils is that either they do nothing, or else when we ginger them in to activity they want to spend far too much because the county architect sees a chance to make a splash". Officials of the Board of Control came to mourn the passing of the percentage grant. In the 1920s it had at least provided some specific incentive for local authorities to act. However, in the 1930s, with the new freedom to spend the block grant, money was shifted to more attractive health services or out of the health budget altogether.[20]

This was symptomatic of a larger truth. Local services in the 1920s had not reached the position where uneven development in relation to scope and standards was merely a function of inequalities in income between local authorities in relation to local needs. Whilst low resourcing was clearly a major cause of poor provision, on the evidence of the Ministry surveys standards of provision, both in relation to health services generally and in relation to specific services, were uneven

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20. PRO HLG 52/1010: National economy, accommodation of mental defectives and persons of unsound mind. Brock to Robinson, 6.10.1931.

principally because of fundamentally different approaches to health care by different local authorities. The surveys merely served to prove the case of those in the Ministry of Health who had argued for the continuance of percentage grants in the 1920s; that local provision had not reached the stage where its future development could be left to the benign discretion of local authorities. Further central stimulus and close central control was still needed. The question that became pressing once the depressing results of the health surveys had been collected in the Ministry of Health was just how effective the new mechanism of central control established under the 1929 Act would prove to be.

2. CENTRAL-LOCAL RELATIONS AND UNEVEN DEVELOPMENT

The results of the health surveys as a basis for the usage of the power under section 104 of the 1929 Act to withhold or reduce grant aid was originally intended to provide the means by which central control could be wielded over local policies. However, the experience of the 1930s proved to reveal that both facets of this new form of central control were inherently flawed. First, in May 1933 public health officials began the task of tabulating the results of the surveys as a basis for comparing local performance on which evaluation of the usage of section 104 could be made. By July 1933 Dr Macewen had concluded that it was difficult to evaluate the adequacy of local tuberculosis services against local

needs, and further that it was, therefore, impossible to compare tuberculosis services between different local authorities except in the most general way. This was because of the huge problems of quantifying local needs and the huge disparities in local needs and conditions that appeared to pertain anyway. He came to the same conclusions in relation to venereal disease services. Efficiency could only be measured comparatively by reference to the facilities and staff provided and the use made of the facilities by the staff.[21]

As a result, Ministry officials acquired great insight in to the nature of the services provided by local authorities and were able to form general impressions, as the survey results show, upon which working comparisons between the performances of different local authorities could be made. However, they were not able to provide a technical evaluative basis on which the Minister of Health could go to the House of Commons and justify sanction against any particular authority under section 104.

In addition, it was soon realised that in the context of the 1930s recession and the sensitivities of local authorities, anxious not to lose grant aid because of the introduction of the block grant or experience any erosion of new-found autonomy, that the power available under section 104 was politically unusable. Its usage on any local authority would have been politically unpopular and

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21. PRO MH 55/22: Papers relating to a general review of progress on national public health surveys, reports by Dr Macewen, 3.7.1933.

divisive, but particularly so if it had been used on a local authority in a depressed area. In such a case it would also have been counter-productive to the desired aim of gaining increased spending on health care, as it would have eroded the already seriously deficient resources at the local authority's disposal. Local resentment would also have been increased, for, in stark contrast to percentage grants where central power could be exerted by not giving grant aid, with the block grant money would have to be specifically taken away through a deduction of a local authority's agreed grant apportionment for a given year.

For these reasons the intended basis for central control was eroded. This would not have been of major importance to Ministry officials had the results of the health surveys been more comforting, as had originally been expected. As it was, the survey results showed serious deficiencies, against which the Ministry had only resort to persuasion and advice. The real means by which the Ministry attempted to exert central control, in the absence of any other means provided by the 1929 Act, was through the medium of survey letters, sent out to each local authority after the relevant survey report had been considered within the Ministry, and subsequent correspondence and, where necessary, re-survey.

In all cases survey letters were sent to local authorities listing criticisms and suggested spending. Ministry expectations of local response varied over time. Those authorities surveyed before the fall of the Labour

Government in 1931 were bid to make immediate response. However, once the National Government had been formed and the economy circular of 1931 issued, expectations were somewhat changed. Ministry survey letters and correspondence suggested that local authorities strike a balance between economy and improvement, addressing themselves to those criticisms and recommendations which either required urgent attention on the grounds of public health or did not involve substantial expenditure. This approach mirrored the Ministry's parallel approach to the use of the power of loan sanction in respect to capital spending. From c1934 onwards Ministry correspondence to all local authorities except those in the most depressed areas reflected the restoration of a Ministry imperative to gain local health improvement and co- ordination and the implementation of the 1929 Act as quickly as possible.

Actual local responses to Ministry survey letters varied. In the case of the better authorities the criticisms were marginal and it can be assumed that they were generally heeded. However, Plymouth was a notable exception in that it was initially surveyed favourably but ignored the suggestions in the survey letter, and, indeed, faced with local economic problems, restricted the development of services, especially the hospital services, in the mid-late 1930s.[22] Ministry pressure and advice was incapable of diverting the council from its changed course. With respect to the authorities found

22. PRO MH 55/16, memorandum by J.C.Wrigley, 28.4.1934.

sufficiently deficient to require re-survey, the general experience of Ministry officials is more difficult to establish as no summary statement of the position by the late 1930s is to be found amongst Ministry papers. Three examples of Ministry relations with deficient county boroughs may be briefly considered to suggest the nature of that experience. Burton-upon-Trent was an example of a relatively wealthy authority, experiencing low unemployment during the 1930s, which was found generally deficient. West Hartlepool was also an authority found generally deficient but with almost the exact opposite social and economic basis. Finally, Bournemouth may be taken as an example of a relatively wealthy authority which was found deficient in a specific way for specific reasons.

Burton-upon-Trent was initially surveyed in 1931 and found to have significant problems in a number of areas. First, the development and organisation of the venereal diseases and blind welfare services did not meet Ministry standards. Secondly, the local authority had inadequate in-patient provision for expectant mothers. Thirdly, the appropriation of Belvedere House, a transferred public assistance institution, as a general hospital under public health legislation, had not been considered. Finally, the local authority had had no consultations with the voluntary hospitals in its area to formulate a co-ordinated hospital policy. The Ministry considered that a solution to most of these problems could be found initially through the appropriation of Belvedere House,

which it considered eminently suitable and requiring little new expenditure. Belvedere House could provide more beds for, amongst others, expectant mothers, who refused to attend it whilst it remained a public assistance institution, and could provide the basis for the authority's planning of a long-term hospital policy in conjunction with the voluntary hospitals.[23]

Despite a survey letter and subsequent correspondence, when the authority was re-surveyed in 1935 much the same problems were encountered. The venereal disease service remained open to censure primarily because it was administered by what Ministry officials considered to be an unqualified and incompetent officer, Dr Brindle. More importantly, Dr Cowie, the medical officer of health, had failed to take any interest in assuming control of former guardian health services. He merely followed his council's direction, and with a strong public assistance lobby within the authority, public health and public assistance services remained separately administered. The poor co- ordination of the authority's health services which resulted was compounded by the fact that although the voluntary hospitals had created a committee Cowie had made no moves to initiate consultation.[24]

In subsequent relations Ministry officials were able to secure certain improvements by Burton-upon-Trent. Dr Brindle, for example, was dispatched on training courses

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23. PRO MH 66/501: Ministry of Health public health survey of Burton-on-Trent county borough.
24. PRO MH 66/505: Burton-on-Trent county borough second survey, November 1935.

and more minor remaining problems in relation to blind welfare and maternity and child welfare education were broached. However, the authority resisted the appropriation of Belvedere House and the creation of a co-ordinated hospital policy throughout the second half of the 1930s. The cost of appropriation it was suggested was too high and the voluntary hospitals were too zealous in the preservation of their own interests to enter in to meaningful discussions. In October 1937 Dr Donaldson, who had conducted both surveys, commented rather wearily that "the arguments against appropriation are those almost universally employed by councils who have no intention of improving their hospital services and can be answered in the usual way". From 1937 onwards Ministry officials ceased to apply consistent pressure on Burton-upon- Trent for the implementation of health reform, having been defeated by a local response mainly conditioned by an adherence to a low rate and inertia on the break up of the poor law.[25]

The Ministry experience of West Hartlepool was no less galling. The survey report in March 1931, also undertaken by Dr Donaldson, uncovered a long list of major problems. There were very low staffing levels, particularly in relation to sanitary inspectors and health visitors. Provision for the treatment of venereal diseases was poor, due mainly to the clinic being sited in a highly public place, therefore, deterring sufferers

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25. PRO MH 66/507: Burton-on-Trent county borough second survey, post survey correspondence, 1935-1939.

from attending. The provision for infectious diseases was inadequate, a fact made all the more incomprehensible by the fact that the authority had bought a site for the building of a new hospital twenty-six years previously but never built on it. There was inadequate provision for pulmonary tuberculosis and very little assistance given to general practitioners in the out-patient treatment of the tuberculous. There was a lack of facilities for x-ray treatment and no definite scheme for orthopaedic treatment. In virtually all respects mental deficiency provision needed improvement. There was little co-operation with the public assistance committee and little prospect of the appropriation of Howbeck Hospital as a general hospital. Finally, there had been no consultations with voluntary hospitals in the area.[26]

Recognition was made of the fact that West Hartlepool was suffering from the worst effects of the recession and that response to Ministry criticisms and recommendations was likely to be affected by this. However, in his report Donaldson suggested that "it cannot be denied that in the past, in the days of the town's prosperity, economy was practiced too much at the expense of the public health services". It remained inherently an authority with a backward approach to public health provision. Ministry officials viewed with sympathy the medical officer of health, Dr Mckeggie, who prior to

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26. PRO MH 66/988: West Hartlepool county borough, public health survey under 1929 Local Government Act, report by Dr Donaldson, March 1931, and D.C.L.Ward to Town Clerk, West Hartlepool, 31.7.1931.

Donaldson's survey had attempted to have his staff increased and Howbeck appropriated, only to have both proposals suspended by the council pending a survey letter.[27] The council's enthusiasm for the suspension of such proposals was revealed when the response to the Ministry survey letter stated that consideration of all of its criticisms and recommendations were to be deferred until a later date. This response was accompanied by a letter from the local M.P., W.G.Howard Gritten, protesting on behalf of prominent West Hartlepool councillors at the Ministry's recommendations for expenditure at a time when economy ought to be practiced.[28]

Ministry officials were appalled at West Hartlepool's wilful suspension of even the most urgent and meagre of improvements. Closer scrutiny revealed that West Hartlepool was primarily interested in rate reduction and had used additional grant aid through the block grant mainly for this purpose in 1931/32. Moreover, J.C.Wrigley wrote to Dr Macewen and Dr Maclachlan, a principal assistant secretary at the Ministry of Health, in February 1932 suggesting that "the expenditure on health services is abnormally low compared with that on other services, though these are well below the average, and the standard attained does not suggest that any exceptionally good value is being obtained for the money

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27. ibid, report by Dr Donaldson, pp.68-72.
28. PRO MH 66/991: West Hartlepool public health survey correspondence 1931-1934. Town Clerk, West Hartlepool, to Secretary, Ministry of Health 12.10.1931, and W.G.Howard Gritten to Minister, 9.10.1931.

which is spent. Dr Donaldson points out that the health services were starved in the days when the town was prosperous and judging from one's general knowledge of the council, I imagine that the council passed their resolution to defer consideration of any improvement without any regrets".[29]

For the following twelve months there followed further letters from the Ministry imploring the council to adopt a more balanced approach between economy and health improvement, which induced replies from the town clerk, Harold Stanton, stating that the council continued to defer consideration of all issues. A flurry of correspondence in November 1932 elicited a further letter from Howard Gritten, the local M.P., to Sir Edward Hilton Young, the then Minister of Health, protesting again at the Ministry pressure on West Hartlepool, and confirming the council's view that, in particular, appropriation of Howbeck would be too expensive. "I am pertinently asked", he wrote in relation to his discussions with West Hartlepool councillors, "whether a Conservative minister is as much under the influence of socialistic bureaucrats as a Labour minister".[30] By February 1933 Ministry officials had for the time being given up trying to persuade West Hartlepool in to making improvements or implementing the 1929 Act. An internal memorandum compared the experience of West Hartlepool with that of

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29. ibid, D.C.L.Ward to J.C Wrigley, 15.2.1932, memorandum by Mr Infield, 23.2.1932 and Wrigley to Macewen and Maclachlan, 25.2.1932.
30. ibid, W.G.Howard Gritten to the Minister, 25.11.1932.

Burton-upon-Trent. "Both councils are extremely obsessed with the importance of economy...both of them are far from satisfactory and will need to be kept under review".[31]

The battle to shift West Hartlepool's position was rejoined when Dr Donaldson re-surveyed the council's health services in 1935. His report again praised the efforts of Dr Mckeggie, who had managed to secure an increase in sanitary and office staff, better premises for the school clinic and improvements in the venereal diseases clinic, although without re-location. Yet, Donaldson concluded that "he has undoubtedly had a very difficult council to deal with, and it was not altogether surprising to find at the re-survey that he had not made much headway during the intervening years". In particular, West Hartlepool still had no hospital policy. This in addition to criticisms and recommendations concerning the services for tuberculosis, child welfare, mental deficiency and venereal diseases formed the text of the re-survey letter in January 1936.[32]

One seed of hope was planted during Donaldson's visit to West Hartlepool with respect to hospital policy. Changes on the health committee had meant that it was no longer dominated by economy minded councillors. The committee and Mckeggie hoped that cautious pressure form the Ministry would help them in their internal council

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31. ibid, J.C.Wrigley to P.Barker (Board of Control), 15.2.1933.
32. PRO MH 66/993: West Hartlepool county borough second survey, report by Dr Donaldson, 29.7.1935, and D.C.L.Ward to Town Clerk, West Hartlepool, 9.1.1936.

struggle for the appropriation of Howbeck. Yet, Donaldson had also met Alderman Hyde, the chairman of the public assistance committee. Hyde was against appropriation. Indeed, Donaldson reported, "he argued that all medical services, under whatever acts they are administered, are "public assistance". He said that Howbeck was all one institution, and that appropriation of the hospital would mean dual control. He expressed the opinion that the public assistance committee should take over all services provided by the council for the relief of those who could not afford to pay for them". Hyde had also objected to Donaldson's suggestions of the need for more staff at Howbeck. Donaldson reported that "Hyde would not believe it and made somewhat offensive remarks about officials always wanting to make work for other officials".[33]

As a result off such prevailing local attitudes the survey letter fell on stony ground. In the three years before the Second World War very little was achieved by renewed Ministry pressure, and the West Hartlepool health committee was forced to embark upon plans for building an entirely new hospital by one of the town's voluntary hospitals. After debate in an office conference in February 1939 even these proposals had to be vetoed on the grounds that they represented an extravagance when general hospital accommodation could be so much more cheaply secured by appropriation of Howbeck hospital, a policy which the council public assistance lobby

33. ibid, report by Dr Donaldson, esp pp.24-25.

prevented. After nearly a decade there was still impasse on the council's implementation of the 1929 Act and its dilatory attitude to the improvement of health services. The Ministry came out of it with little achieved.[34]

One might have expected Ministry officials to have had more success in relations with an authority which otherwise seemed to have a progressive approach to health provision and potentially could be persuaded to overcome a specific deficiency. Yet relations with Bournemouth County Borough Council suggested otherwise. Dr Donaldson's report in April 1932 praised the council's venereal disease scheme and the establishment of a post-natal clinic. Yet, the problems of provision for the tuberculous were but the tip of an ice-berg. The improvement of provision entailed essentially greater residential accommodation. In this respect Donaldson's report suggested that the council was likely to be indigent because of a deep-rooted opposition to public hospital provision which mitigated against the appropriation of Fairmile House as a hospital in which all the tuberculous could be treated. Indeed the medical officer of health, Dr Henry Gordon Smith informed Donaldson that he "found that the Bournemouth Council were largely uninterested in public health matters. The policy of the council has been to develop Bournemouth as a holiday and residential town, and to get away from the original conception of it as a health resort. The result

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34. See PRO MH 66/995: West Hartlepool county borough re-survey correspondence, 1936-1939.

is that certain members of the council have developed a rather ridiculous "orgueil" and refuse to believe that this particular town can be as other towns, which need organised medical services....these members believed that voluntary agencies were sufficient to cope with all the public health services".[35]

The Ministry's survey letter in 1932 stressed the need to develop provision for tuberculosis and as part of this to appropriate Fairmile House. Ministry officials wanted the council to make Gordon Smith the medical officer for the whole council in order to bring about a co-ordination of all the council's health services.[36] The appropriation of Fairmile House was, however, successfully opposed on the council. Later, in 1935, Dr Asten, the chairman of the public health committee, informed Ministry officials that "the question was erroneously regarded as purely political and the overwhelming Conservative majority looked upon appropriation as a socialist measure which should be opposed".[37] Opposition to appropriation on the council did not, however, preclude the following of other routes to meet the Ministry's recommendations. An ill-conceived plan for a tuberculosis and infectious diseases hospital in 1932 was followed by negotiations with both Poole

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35. PRO MH 66/473: Bournemouth county borough, public health survey, report by Dr Donaldson, April 1932, p.10.
36. ibid, H.H.Turner to Town Clerk, Bournemouth, 13.8.1932.
37. PRO MH 66/476: Bournemouth public health survey, post-survey correspondence, note of meeting between chairman of Bournemouth public health committee and medical officer of health with officials at the Ministry of Health, 13.6.1935.

Borough Council in late 1934 and Dorset County Council in early 1935 for new joint provision. The negotiations with Poole, however, broke down as a result of the latter's change of heart and insistence that tuberculosis patients be not taken by the planned hospital. Further, Dorset pulled out of negotiations as a result of what the council perceived as extravagance in planning on the part of Bournemouth.[38]

Nevertheless, in June 1936 Bournemouth public health committee were given the go ahead by the council to plan a new tuberculosis hospital and whilst the Ministry still ideally wanted tuberculosis provision to be made in an appropriated Fairmile House loan sanction for the purchase of land for the building of the new hospital was given in May 1937.[39] What occurred in Bournemouth's policy on tuberculosis provision in the second half of the 1930s is unclear from Ministry correspondence, but nothing had been achieved by 1939. One can only assume that the root opposition to new hospital provision and the provision of good facilities for the treatment of tuberculosis, observed by Dr Donaldson in the early 1930s, reasserted itself. Relations based upon persuasion and the power of argument had achieved as little for Ministry aims for health service improvement with regard to Bournemouth as they had done with regard to Burton-upon-Trent and West Hartlepool.

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38. ibid, note of visit by Arthur Macnalty (Ministry of Health) to Bournemouth, 2.7.1933 and J.N.Dark to Town Clerk, Bournemouth, 29.5.1935.
39. ibid, note of meeting at the Ministry of Health, 13.6.1935.

There is strong evidence to suggest that the lack of success for the Ministry in relations with these three authorities was symptomatic of the wider experience of relations with local authorities found sufficiently deficient in the initial survey in the early 1930s to require re-survey. The overall lack of Ministry success by 1935 with regard to influencing Plymouth and the local authorities that were initially surveyed unfavourably can be seen in the results of re-survey shown in figures 5 and 6. Although the Ministry's summary conclusions, again expressed in their own words, are incomplete, they suggest that only in four cases of seriously deficient authorities were there great improvements in provision noted before 1935. These were Berkshire, Blackpool, Grimsby and West Bromwich. In the case of Berkshire improvement came as a result of the appointment of a new and better qualified medical officer of health. In the rest of the deficient authorities little or no progress was observed. Warwickshire openly resented the interference of central government and point blank refused to take any notice of the survey letter criticisms. Others with justification continued to plead poverty. Leicestershire, for example, postponed further action on financial grounds. The rest simply continued in their chosen course, participating with Ministry of Health officials in the procedure of central-local relations, - surveys, survey letters, conciliatory replies, re-surveys and strong Ministry pressure - but continually fobbing them off with delaying tactics.

Amongst these there continued to be richer and poorer authorities alike. A Ministry official summed up the situation when he wrote of the action taken by Oxford in respect of its deficiencies, "Much talk but nothing concrete has emerged".[40]

Often, as has been shown by the examples of West Hartlepool and Bournemouth, the local medical officer of health was in agreement with Ministry criticisms and would use the survey letter as a means of trying to persuade his elected members of the necessity of improvement. Whilst such a tactic could gain progress in relation to services organised before the 1929 Act, rarely did it shift strong politicised sentiment over the unity of public assistance services, or scepticism concerning a permanent role in hospital provision, which, in any case threatened the viability of voluntary hospitals, on whose boards of governors many prominent councillors sat. In other authorities members and officials would pass the buck of responsibility for deficiency in local provision so effectively that the central official would be unable to get a grip on the local policy making process so as to change local policy. Ultimately, when extensively pressured, local councillors quite legitimately referred to the contradictory central pressures for prudence and care of the rate in defence of inaction.

Given the evidence provided by the three case studies it is reasonable to posit the view that this general

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40. PRO MH 55/16, memorandum by J.C.Wrigley, 28.4.1934.

description of central-local relations for the period up to 1935 may broadly apply to the whole of the 1930s, especially given the fact that rate stabilisation remained such a high priority for so many authorities. In relations with all authorities the persuasion which Ministry officials attempted to exert may have been much more effective had the ultimate sanction of block grant reduction or suspension appeared a real threat. However, local authorities were as mindful of the impotence of section 104 of the Local Government Act in practice as Ministry officials. Consequently, local authorities with deficient services largely continued with their existing policies, some by necessity, others by choice. Ministry public health officials and inspectors dealing directly with individual authorities had to be content with a jockeying role. By the late 1930s there is much evidence that such officials were only too well aware of the impotence of their position, and, as a result of the financial and administrative circumstances of local government and its freedom from greater central control, the seriousness of uneven development in local health care. Extrapolating from the 1935 figures in 1939 21 counties and 20 county boroughs were still considered by the Ministry to be well below desired levels of development. The equalising effects of the block grant on local authority finances had been by no means substantial enough, and the freedom from central control had had the adverse effects on local policies feared by some outside central government in 1929. The Ministry

was powerless to reverse this trend. This constitutes further evidence for the endorsement of a pessimistic view of local health provision throughout the 1930s, caused in part by the changes wrought by the 1929 Act.

3. THE FUTURE OF HEALTH CARE REFORM

In the light of their experience of the health surveys, the implementation of the 1929 Local Government Act and relations with local government during the 1930s, it is perhaps surprising to conclude that officials at the Ministry of Health remained in favour of local government as the focus for further health care reform. The Midwives Act of 1936 and the Cancer Act of 1939 both added significant new responsibilities to those already bestowed upon local government, and in planning for the nationalisation of the voluntary hospitals and an extension of the national health insurance principle during the Second World War Ministry officials looked upon local government as the ideal administrative umbrella. Yet, it was entirely within the logic of the bureaucratic elite to think along such lines. Local government had been the focus of health care reform after the First World War precisely because it involved only an incremental extension of the role of existing institutions of state provision which it had been believed would not threaten the governing interests of central government. Centralisation or development by way of an extension of a general practitioner-led national

service had incalculable implications. Moreover central policy implementation through local government perpetuated a means of administration with which central officials were well versed. So again was the logic of policy development in the 1930s, and potentially beyond, when health care reform was required, irrespective of the practical realities of health administration by local government.

It is not too fanciful to suggest, therefore, that but for the intervention of the Second World War, the experience of the emergency medical service which revealed the potential of a nationally run system of health care, the publication of the Beveridge Report and the ensuing policy debate, that the extension by degrees of a state run health care system primarily through local government could have been predicted. Local councillors and officers generally expected that in view of the severe financial problems faced by the voluntary hospitals by the late 1930s that they would inevitably come under their charge, and that this would precipitate more enthusiastic approaches to appropriation of public assistance institutions as general hospitals and local hospital co-ordination than seen during the 1930s. The relationship between local authority and general practitioner services, nevertheless, would have remained problematical.[41]

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41 For a study which reflects this attitude as well as providing a detailed case study of hospital development in one region see J.V.Pickstone, Medicine and Industrial Society, A History of Hospital Development in Manchester

The continuation of a bureaucratic consensus on local government as health care provider did not, however, extend to the means by which local health care was to be centrally funded. It had been an agreed part of the settlement with local government in 1929 that any subsequent new health services bestowed upon local government should attract new funding. This issue was then pertinent with respect to the new responsibility for midwives work from 1936. Rather than add funds to the block grant, distributed in theory if not in practice on a needs basis, a new specific percentage grant was instituted. This was perhaps not as extraordinary as it may seem as even in the making of the 1929 Act Ministry officials still essentially recognised that in the stimulation of a new local authority service the percentage grant was the appropriate form of exchequer assistance. Moreover in its distribution the grant for midwives was to contain some criteria of need. However, when, at the beginning of the Second World War, the Ministry moved to institute a special grant for venereal disease provision, which was already covered in the block grant, it was apparent that the Ministry's support of the block grant principle in relation to health services was again in question as it had been in the early 1920s.

The source of the Ministry's move for a special venereal diseases grant was the expectation of a rise in the incidence of venereal disease amongst civilians in

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and Its Region, 1752-1946 (1985), in particular, pp.264-268.

war time, which would then rapidly spread. After their experience of high local authority deficiency in provision and unresponsiveness to central pressure without a direct financial stimulus during the 1930s the public health division of the Ministry was aware that a special percentage grant would be necessary in order to push local authorities to extend their services or even to bring them up to a reasonable standard. Initially, such a proposal was blocked by the accountant- general's division within the Ministry. However, in December 1939 the public health division made representations direct to Walter Elliot, then Minister of Health, who duly wrote to Sir John Simon, then Chancellor of the Exchequer, proposing a 75% grant.[42]

Simon, under guidance from Treasury officials, wrote a stinging reply which backed up the accountant-general's division's initial position against a special grant. Simon found it incomprehensible that Elliot should want to make an additional grant for a service which was already provided for under the block grant, and in a way which would reward backward authorities for their poor provision previously. If local authorities were not providing services sufficiently extensive to meet need then they should be treated with section 104 of the 1929 Act. He concluded that to assume "that authorities will not perform their duty without financial stimulation

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42. PRO T 161/1176/S.18153/1: Treatment of VD, expenditure by local authorities, Ministry of Health circulars, 1922-1940. Internal Treasury minute from Mr Tribe to B.W.Gilbert, 7.12.1939 and Walter Elliot to Sir John Simon, 1.12.1939.

seems to me to be the negation of the whole block grant system and indeed to suggest that the system of local government in this country is in a bad way".[43]

With these words Simon summed up the conclusions of Ministry officials, who had at first hand experienced the implementation of the block grant and central-local health care relations during the 1930s. The Ministry complied with the Treasury's wish that a circular be sent out to local authorities merely urging them to prepare venereal disease services for additional patients. However, after receiving only letters of protest from local authorities in reply, Malcolm MacDonald, the new Minister of Health, came clean about the Ministry's complete impotence in relations with local government with respect to health services funded by the block grant. He informed Sir Kingsley Wood, Simon's replacement as Chancellor of the Exchequer, in September 1940 that "the suggestion made by Sir John Simon that this situation might be met by threatening withdrawal of grant under section 104 of the Local Government Act, 1929, seems to me not merely impracticable but indefensible. Such a step has never yet been taken, and it would indeed be a double-edged weapon. Even if the action were taken on the strongest possible grounds, the effect would almost certainly be a storm in local government circles, and a reduction rather than an increase in the services provided by the penalised

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43. ibid, Simon to Elliot, 20.12.1939.

authority".[44] With great reluctance the Treasury now complied to the Ministry of Health's proposal for a special venereal diseases grant, B.W.Gilbert commenting ruefully to a Treasury colleague that "once we start restoring in any degree the percentage grants which were absorbed in the block grant, there is no knowing where we shall stop". The grant was given only on the basis of it providing no future precedent for grant reform.[45]

To a large extent, however, these deliberations in 1939/40 did presage subsequent changes in grant funding of local health care services. Under the 1946 National Health Service Act, local authorities lost responsibility for hospital provision but, nevertheless, retained a key role in domiciliary and out-patient health care services. The form of exchequer aid was to be a 50% grant for all local health services net of approved expenditure. Thus a return was made to the financial stimulus of the percentage basis of grant aid, to the specification of grant aid to be spent on health services, and to a more specific form of grant aid control. These had all been given up in the 1929 Act and were restored after the experience of health provision and central-local grant aid relations during the 1930s. At the same time, however, the grant was general to all health services, leaving local authorities discretion in local spending on

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44. PRO T 161/1176/18153/2: Treatment of VD, expenditure by local authorities, 1940-1945. MacDonald to Sir Kingsley Wood, 9.9.1940.
45. ibid, Gilbert to Sir Alan Barlow, 17.9.1940.

different health services.[46] That the experience of the 1930s provided an endorsement for those in the Ministry who had argued against a block grant for health services and lost in the 1920s, and led much more clearly to the future reform of the finance of local health care and grant aid relations with central government, than to that of the future role of local government in health care appears an appropriate conclusion.

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46. D.N.Chester, Central and Local Government: Financial and Administrative Relations (1951), p.382.

CHAPTER SEVEN

CONCLUSION

It is to be remembered that the scope of this thesis was limited from the start. It provides an analysis of the formulation and implementation of only the poor law and exchequer grant reforms in the 1929 Local Government Act. Even then it is primarily concerned with the poor law reform as a reform of local government and of local health care, and with both reforms only in relation to England and Wales outside London. It is also an analysis primarily based on qualitative evidence. The scope for further research in relation to the 1929 Local Government Act, therefore, remains vast. Not only do the other provisions of the 1929 Act need to be considered in depth, but some more systematic studies of the implementation of public assistance and the fate of the workhouse in the 1930s, and the poor law and exchequer grant reforms in relation to London and in relation to Scotland need to be undertaken. With respect to the focus of analysis in the present thesis much more could be learned from a quantitative evaluation of the block grant as a grant aid control and in terms of its impact upon local authority finances and spending patterns. Further, analysis could be extended to the nature and problems of block grant distribution among second tier authorities during the 1930s and county council second tier relations over finance and service provision. Finally, greater understanding of the implementation and

impact of the 1929 Act would clearly be gained from a systematically comparative study of individual local authority cases with reference to both finance and health care provision and central-local relations.

This is a future agenda for research. What the present thesis was concerned to achieve was the rescue of the study of the 1929 Act from a state of backwardness. By taking specific parts of the Act as a focus for study the thesis aimed to make a step towards suggesting the arena for debate, put forward a substantive contribution to knowledge and means of re-interpreting the 1929 reforms, as well as providing a basis upon which future debate of the 1929 Act may proceed. Such claims risk the accusation of pretentiousness, and the judgment of failure. Yet, the highly fragmented nature of the literature on the 1929 Act, its absence from consideration by most inter-war historians of public policy, and its omission or at best fleeting mention in text book overviews of the history of the inter-war period, economic and social policy, government and, indeed, local government, represent compelling evidence why such an attempt upon the lines described above should have been made. This final chapter summarises the fruits of that attempt.

Having established a context to the understanding of the 1929 poor law (health care) and exchequer grant reforms and explained their content the thesis was first concerned to synthesise existing work in relation to the origins, achievement and implementation of the reforms as

a basis for discussion. A number of conclusions were reached. First, the origins of the 1929 reforms are generally held to be found in the identification of problems of local government, central-local relations and public policy, and the rationally conceived solution thereof, in the years before the end of the First World War. The problems of an anomalous structure of local government and the inefficiency of too many local authorities with overlapping functions in health care were to be solved through the abolition of separate poor law authorities, the transfer of their services to county and county borough councils and the unification of local health responsibilities under their charge. Prescriptions for reform on this basis were first made by the minority report of the Royal Commission on the Poor Law in 1909 and then decisively in the Maclean Report of 1918.

Problems were also identified in relation to central-local financial relations. First, financial resources between local authorities were seen as inequitable and percentage grants were perceived as perpetuating such inequalities. Secondly, percentage grants were perceived as giving local authorities, rather than central government, control over aggregate levels of grant aid. Finally, percentage grants had become associated with a high degree of central administrative control at the expense of local autonomy. Such problems were to be solved by the introduction of the block grant principle, which allowed distribution of grant to individual

authorities on a needs basis, the fixing of aggregate grant aid by central government, and a greater freedom for local authorities in the spending of grant aid once received. This solution was promoted both in the minority report of the Royal Commission on Local Taxation in 1901 and then again by the Kempe Committee in 1914.

The achievement of these solutions to prescribed problems is then widely considered to have been based upon the neutral and uncontroversial development of reform proposals in the Ministry of Health in the period immediately after the First World War. A Ministry view on poor law reform and a limited exchequer grant reform was enshrined in the Mond memorandum of 1921. The failure to achieve reform in the early 1920s is accounted for by the obstacles presented by financial crisis, the wider deliberations conducted by the Meston Committee and the desire by the Treasury for a more wide-ranging block grant reform, and the lack of strong ministerial leadership. Nevertheless, the Mond memorandum remained the Ministry view and was placed before Neville Chamberlain in late 1924.

Chamberlain is then presented as the liberal hero of reform. A man with profound desires to carry social reform for the good of the people, he recognised the utility of the Ministry of Health plan to the attainment of a major health reform and the provision of assistance to the necessitous areas of the country. His expertise and dedication won him the respect of Ministry officials and together they enhanced the quality of the reform

proposals. Chamberlain performed the vital function of winning the achievement of the reforms in Cabinet, despite the delays caused by even more consideration of block grant reform by the Barstow Committee and a committee of ministers, Cabinet worries over the effect of poor law reform on the Conservative rural vote, and Churchill's derating initiative.

Chamberlain also ensured that the reforms met the plurality of interests involved, by making concessions to guardians and to local authorities which stood to lose by a change in the exchequer grant system. Such concessions, whilst placating these major interests, did not undermine the essential principles involved in the reforms. As a result Chamberlain and the Ministry of Health achieved major reforms, facilitating the long-overdue modernisation of local government and central-local relations in the interests of all those concerned. Contemporary praise for the 1929 Act is echoed by a large number of subsequent analysts.

The implementation of the 1929 reforms has been less widely researched, but major works suggest that the block grant was generally successful as a means of controlling exchequer grant aid and that the Treasury sought again to extend the number of local authority services covered by the block grant principle. The block grant was less successful as a means of redistributing grant aid towards poorer authorities but this is generally held to be due to the unforecastable effects of the recession which eroded the redistributive effects of the block grant.

Even then the review of the block grant formula made good what defects were discernible in the grant's ability to distribute on the basis of local need, and the evidence of the Ray Committee and contemporary writers suggests that local government generally endorsed the block grant both as a means of fairly meeting local government's financial needs and allowing it greater autonomy.

Problems in the implementation of the poor law reform and the local provision of health care in the 1930s are readily admitted, but are again generally put down to problems which could not have been foreseen in 1929. Suggestions have been made that some authorities were too poorly funded or too apathetic to provide efficient health services, and that the power of grant reduction held by the Minister of Health was an empty one in practice. These, however, are countered by the arguments that poor funding was not due to any inherent failure in the block grant but to the unforecastable effects of the recession, and that what may be seen as local apathy may be explained away by a discussion of many other contingent factors to reform. There is also the generally optimistic interpretation of health standards in the 1930s which questions the necessity for wide-ranging usage of Ministry powers over local authorities.

Hence, the study of implementation, where made, has been able to endorse the role of the 1929 reforms as part of the long-term liberal improvement of the institutions of government to meet prescribed problems. The structure of local government rationalised in 1929 lasted until

1972. The financial regime instituted in 1929 became a model for all future reform, and may be said to have only undergone a fundamental re-think in the late 1970s. Finally, the role of local government as a major direct provider of social policy has been endorsed ever since and has only come under serious attack in the 1980s.

The rest of the thesis then took these conclusions as a received orthodoxy, or model of analysis, to be looked at critically, focusing on the formulation and implementation of the reforms themselves rather than their fate in the world of inter-departmental relations and high politics. Chapter two, first, questioned the presumed rationality of the 1929 reforms as solutions to prescribed problems. Other contemporary analyses suggested that the block grant far from enhancing local autonomy eroded it by making local authorities evermore dependent upon central funding, and that the expenditure control priorities in its inception threatened the very fiscal basis necessary for efficient provision of local services. Alternatives were proposed which focused on the introduction of new sources of local income. This held greater potential for creating greater local autonomy and reducing local reliance on grants, and, therefore, the importance of greater central control over aggregate levels of grant aid. If percentage grants were continued a revision could have been made which ensured that they were more related to individual local authority need. Analysts also suggested that the block grant as a solution to problems of inequitable resourcing of local

authorities faded in comparison with the alternative option of reforming local rating areas so as to make local authorities in themselves more equitably resourced.

Contemporaries also poured scorn on the reform of the poor law as a solution to prescribed problems of public policy. At a general level many considered the concentration of the local government structure on the basis of counties and county boroughs, which the poor law reform provided for, as inadequate to the needs of efficient local provision in a period of great economic and social change. Larger regional bodies were suggested as an alternative. In addition, responsibility for the unemployed poor, it was suggested, could much more appropriately have been made a national one, in response to the growing recognition during the 1920s that the causes of unemployment were national and international rather than local. Similarly, health reformers from before the First World War had begun to think of the efficient co-ordination of health care as requiring the inclusion of all health services in one state medical service, rather than simply those organised at a local government level.

The contemporary discussion of these alternatives merely served to prove that the 1929 reforms were based upon only one set of options for reform amongst a host of others. As a result one should see the origins of the 1929 reforms as not being based in the rational development of solutions to prescribed problems, but rather in choices that were made between options and the

reasons for those choices, recognising that central government did not seriously consider alternative options to those chosen, a factor which is assumed in the liberal interpretation. Chapter two, therefore, secondly, discussed other ways of conceptualising the rationality of the origins of the reforms other than in the liberal interpretation; of why and how the reform options endorsed in 1929 were originally chosen after the First World War. Various marxist critiques were formulated and whilst their individual explanations were found deficient, the notion of reform being made in the interests of certain sections of society over others was embraced. Discussion thereafter dealt with the perception that policy was made by and in the interests of governing elites. An explanation of reform by the theory of corporate bias was found to be historically inappropriate to an understanding of the inter-war governing process, but Webb's theory of bounded pluralism was found to be an appropriate basis upon which to formulate an alternative context to the way in which the reforms were formulated and implemented. By this it was recognised that reform could be based upon general calls for reform , but that the detail of reform was established within a governing elite. It was proposed that for the inter-war period this should be best characterised in terms of a bureaucratic elite. Further, the notion that policy reform choices were made in an incrementalist fashion, so as to ensure that new policy branched off from existing policy, which was consistent

with bureaucratic imperatives, was embraced. It was, however, recognised that even within government departments there was a high potential for policy debate, and in relation to the local government reforms, the one inter-war politician universally accepted as active, Neville Chamberlain, was involved.

It was further proposed, in relation to the theory of bounded pluralism, that as well as being pushed generally towards reform by interests outside government, elite policy makers would also need to access or take account of interests outside government in the making of the detail of reform, but that they would have a choice over who to access. A consideration of the theory of the intergovernmental network suggested that the principal interests taken account of and accessed would be the local authority associations representing the local authorities on whom elite policy makers were dependent for the implementation of reform.

This theoretical perspective was set up as an alternative approach to the study of the formulation and implementation of the reforms, making explicit the basis upon which the received orthodoxy was being critically examined. The final section of chapter two duly reconsidered the origins of reform. This concluded that rather than seeing the adoption by the Ministry of Health of proposals to reform the poor law in 1919 as part of a continuum in policy development towards reform from before the War, until the War there was little to suggest that reform would be promoted. The War was vital in

throwing up general calls for social reform, which government responded to with an adoption of poor law reform in the Maclean Report. It represented the most well developed reform option available to elite policy makers, and limited health reform to a branching off from existing policy through existing institutions of local government. Other reform options for health care or for the greater efficiency of local government provision through area reform were quickly discarded.

Perhaps, more surprisingly, the section also showed how the Ministry of Health did not automatically embrace plans for block grant reform allied to poor law reform. Nor, when it did, could the principal stimulus be said to have come from within the Ministry of Health on account of its general responsibility for local government. Rather the adoption of a limited block grant reform allied to poor law reform was only made as a result of Treasury concern over increases in grant aid as a result of post-war social reform, and its incremental promotion of block grants to be allied to any such reform. Such promotion was made through new finance officers in spending departments. It is in this context that the successful insertion of the block grant principle in to Ministry of Health plans by Ernest Strohmenger, the Ministry accountant-general, should be seen.

Chapter three then showed that previous arguments concerning the neutral evolution of proposals on the basis of poor law and block grant reform within the Ministry of Health are groundless. Whilst much of the

development of proposals for poor law (health care) reform was technical in nature, Ministry officials inserted their own plans for a strong county council role with regard to relations with second tier authorities. This was present in the Mond memorandum and remained little watered down in to the proposals put before local government in 1925. Further, there was considerable intra-departmental conflict over proposals to embrace the concept of health centres in the reform. Public health division arguments defeated those of the accountant-general in the preparation of the Mond memorandum, but by 1925 the reverse was the case.

More importantly, there was considerable division over the adoption of the block grant principle. In the preparation of the Mond memorandum public health officials argued forcibly in favour of the retention of percentage grants for local authority health services. Strohmenger's plan for a block grant allied to poor law reform was inserted in to the Mond memorandum with the crucial support of the permanent secretary, Arthur Robinson, but even then intra-departmental conflict continued. For it would be fallacious to suggest that the Mond memorandum merely remained on the shelves as the Ministry view on reform until Chamberlain's arrival at the Ministry in 1924. In August 1921 and again in April 1922 Strohmenger made proposals for the introduction of a health block grant unallied to poor law reform, on the latter occasion getting as far as being recommended by Robinson to his minister, Sir Alfred Mond. On both

occasions and in the preparation of evidence for the Meston Committee, public health officials argued against Strohmenger's proposals and for the retention of percentage grants. Then between late 1922 and late 1924 Strohmenger's proposal of a block grant lost the unequivocal backing of Arthur Robinson. This was partly due to the arguments of senior public health officials such as Sir George Newman, the chief medical officer, but, as was later shown in chapter four, this was also due to the perception of a growing opposition to the block grant principle in the local government world. Consequently, when Chamberlain came to office in late 1924, Strohmenger only ensured that the Mond memorandum would be presented to Chamberlain as a basis for reform, complete with the proposal for block grant reform, by showing the financial impracticability of poor law reform without block grant reform.

Chapter four then reconsidered the role of actors and interests outside of the bureaucratic elite in the achievement of the reforms. Section one cast doubt upon the liberal social reform motivations of Neville Chamberlain in promoting the Ministry of Health plan for reform. It concluded that Chamberlain was committed to social reform through local government reform as much if not more so for party political reasons. It was electorally necessary for the Baldwin Government to be perceived as one of social reform. Moreover, Chamberlain endorsed the Ministry's specific programme for reform in the context of debate upon similar lines in the

Conservative party. Conservative imperatives in social reform were very much in line with those of the bureaucracy. It is for these reasons that Ministry officials and Chamberlain enjoyed such close collaborative relations in formulating the reforms, a point born out by a comparison with Ministry relations with John Wheatley, the Labour Minister of Health, in 1924. The Labour party in government were not perceived as embracing the values and aims of the bureaucratic elite in the same way as the succeeding Conservative government.

The section also showed how Chamberlain developed party political motives for reform whilst in office. The poor law reform became a major means by which the power base of the Labour party in local government, and thus their stepping stone to success at a national level, could be eroded. Similarly, the block grant became a cheap means of having a necessitous areas policy, thus keeping within public expenditure policy whilst providing a basis for dismissing Labour claims that the Conservatives did nothing for the poorer areas of the country affected by the slump. Chamberlain's own rationale for a block grant became crucial to its retention in reform plans when in 1926, as a result of local authority association hostility, senior Ministry officials wavered once again. This section, therefore, suggests very different reasons why Chamberlain was so active in relation to local government reform, and provides a case against those who have previously argued that Chamberlain did little more

than promote reform plans previously worked out by officials.

Section two then established the views of the county and county borough councils on local government reform during the early 1920s and showed how important these views were to Ministry consideration of reform at that time. Both the CCA and the AMC only accepted the principle of poor law reform with significant riders which suggested the prospect of considerable dissent to Ministry plans. Meanwhile in the period up to late 1922 both the CCA and the AMC appeared to favour the introduction of the block grant principle in to central-local financial relations. It was, therefore, an essential part of Ministry logic in the Mond memorandum of 1921 to include a block grant proposal as a dupe to get local authorities to accept poor law reform. This was not the end of the story, however, as previous analysts have suggested. By late 1922 it was clear that the CCA was split on the block grant issue and only a minority accepted it. In this context the inclusion of a block grant reform in the Ministry's plans failed to have the advantage of compensating local authorities for poor law reform. As a direct consequence senior Ministry officials became less committed to the block grant reform and its inclusion in the 1925 proposals was made only on the basis of powerful arguments by Strohmenger in late 1924 and in the knowledge that it would arouse powerful opposition.

Section three then showed how Chamberlain and the Ministry, far from seeking to ensure that the reforms met the full plurality of interests, did indeed limit the range of access to reform debate, in particular, directing the Royal Commission on Local Government towards other issues. This limitation of the scope for access for interests outside government meant that alternative reform options would not be discussed and, therefore, that reform would not meet the full plurality of interests, only certain sectional interests beyond those of the elite policy makers themselves. In one important way the provision of access was forced. This was in relation to Chamberlain's discussions with Conservative backbenchers representing rural guardian feeling. Principally, however, access was given to the local authority associations voluntarily, suggesting the very great relevance of the concept of the inter-governmental network. Appeasement of these interests accessed only gave the reforms finally enacted the appearance of pluralism.

The added importance of the concessions given to these accessed interests in the 1929 reforms was that it was not the case that they did not undermine the main principles of the reforms. Indeed, they very materially eroded the potential for success that the reforms held for meeting prescribed problems of local government, central-local relations and public policy. The 1929 reforms were at root limited solutions to these problems. The development and revision of reform in the late 1920s

further eroded their potential for success. First, concessions made to rural guardian feeling eroded the aim of gaining a unity of public health administration in county areas, and by allowing the continued influence of former guardians on public assistance committees after reform seriously eroded the possibility of gaining the unification of health services and co-operation with voluntary hospitals both in county and county borough councils. Discussions with local authority associations had much less effect upon the formulation of poor law reform from 1925, but the opposition of the AMC to arrangements in county areas was only overcome by the dropping of proposals for a strong county council role in relation to second tier authorities.

Relations with local authority associations were, however, much more significant in eroding the potential for success of the block grant with regard to its prescribed aims. Both the AMC and CCA, essentially representing the interests of richer local authorities who stood to lose grant aid income by the replacement of health percentage grants for a block grant, whilst formally accepting the block grant principle in 1926 put all of their efforts in to safeguarding the interests of richer authorities rather than enhancing the potential for success of the grant's redistributive aim. The concessions they received in return for their endorsement of the block grant reform, whilst not fully meeting their aims, thus eroded the redistributive aim of the grant. Most importantly, the needs-based formula as a basis for

distributing the grant was to be phased in meaning that until 1937 only 1/4 of the grant was to be distributed on the basis of the formula.

Central failures to gain rating and valuation reform and the formulation thereafter of a cocktail of factors, which in themselves, and as a result of being based almost totally upon nationally collected statistics, were questionable indicators of local need, further meant that the potential for the operation of the formula to redistribute grant aid to where it was needed was eroded. With respect to the detailed formulation of the block grant formula the local authority associations again showed themselves to be primarily interested in promoting amendments which would have made the formula more helpful to local authorities who had done well under the system of percentage grants rather than enhancing its redistributive capacity. As a result the interests of poorer authorities were not effectively represented in the final deal done between Chamberlain and the local authority associations over block grant reform, and the formula passed in 1929 remained essentially that formulated within the Ministry of Health.

As a result, the 1929 reforms only represented a pluralist success in terms of appeasing all of the conflicting interests in central government, and those powerful vested interests given access from outside the governing elite. Appeasement of guardian sentiment and acceptance by the local authority associations suggested that the reforms had received the acceptance of the

country at large. However, the bureaucratic and political imperatives which ensured the selection of the highly limited reform options on which the 1929 reforms were based and the governing approach to managing discussion with interests outside government meant that the 1929 reforms were not greatly in the interests of the country at large. The Webbs clearly indicated the inherent flaws in the Act to achieve a major reform of provision for the poor and of health care, and beyond the weighty words of the local authority associations were the local authorities in poorer areas of the country who recognised that there was little in the block grant reform to meet their immediate needs. Without more needs-related grant aid the aim of better health care provision as a whole in poorer areas also could not be expected. Recognition of the unknown implications of an additional sum in the block grant to the capacity of the block grant as a grant aid expenditure control, and of greater local autonomy in grant aid expenditure to the provision of local health services, adds final weight to the conclusion that in 1929 the potential for the 1929 reforms to achieve any of their prescribed aims was highly questionable.

Chapter five then charted the dismal failure of the block grant in implementation in regard to its prescribed aims. Contrary to previous belief it failed as a means of grant aid control. This was primarily because of the recession which led to reductions in local grant aided expenditure, and, therefore, of percentage grants, in the

early 1930s. The block grant, including an additional sum of £5 million and being fixed, represented a major boon to local finances over and above what local authorities would have received from the exchequer had there been no reform in 1929 and percentage grants continued in existence and fallen in amount in line with other percentage grant aid. Whilst the trend in local expenditure moved upwards again in the mid 1930s the exchequer still suffered a net loss in grant aid during the second grant period, and crucially, local grant aided expenditure in 1935-36, on the basis of which the additional sum for the third period was set, showed a huge jump on previous years. Consequently, the block grant in the third period also represented a net subsidy to local government compared to if there had been no reform in 1929 and percentage grants had continued.

Throughout the 1930s, therefore, the block grant failed as a grant aid expenditure control. The story of this failure was further marked by reprehensible damage limitation exercises conducted by the Treasury. This was most marked in relation to the Treasury's retention of remanet grants, which in the spirit if the not the strict letter of the 1929 Act should have been paid to local government. It was also to be seen, however, in the strict observance in 1933 and 1937 of increasing the block grant for the second and third periods by the minimum amount allowed by the 1929 Act, and by the siezing of the opportunity, provided by the large amount of new money provided in the third period, to merge local

authority Unemployment Assistance Board contributions in to the block grant. With some justice local authorities could have claimed that it was unfair that they should pay any such contributions at all, and the merger of the contributions in to the block grant headed off any local authority campaign upon the issue.

The second section of the chapter then charted the more predictable failure of the block grant to provide grant aid to local authorities more on the basis of need. Until 1937 the grant formula was only operating on 1/4 of the block grant. In the first period the formula, having been formulated primarily as an index of need for 1929, had some success in its redistributive aim, but the inherent deficiencies in the formula and its inconsistency in compensating individual authorities for their grant and rate income losses meant that such success was highly limited. The effects of the recession on local service need in poorer areas only served to exacerbate the inherent ineffectiveness of the block grant to achieve its redistributive aim. In the second period the problems of the formula came fully home to roost, distribution of the grant on the basis of the formula being highly random, and, indeed, because of the importance of the factor of population in the formula, achieving most help to richer areas of southern England experiencing population growth.

Set against the requests of poorer local authorities for a fundamental reform of the block grant, the review of the block grant formula between 1935 and 1937, which

resulted in only minor revisions of the formula and embraced the retention of population as the principal factor, is, therefore, to be seen as essentially a re-run of the approach to managing inter-governmental relations and its consequent appeasement of only bureaucratic imperatives and the richer local authorities, primarily represented by the local authority associations, which was observed in the run-up to the 1929 Act. Evidence of local government endorsement of the block grant by the Ray Committee should be seen primarily in terms of richer authority enthusiasm. The inability of the formula to assist poorer authorities relative to their need in the third grant period, in spite of acting upon 50% of the block grant, was no less apparent than earlier in the 1930s.

The final section, therefore, revealed how further thinking, whilst endorsing the block grant option as the model for future reform, learned from the revelation of inherent defects in the 1929 reform. The Treasury far from enthusiastically pursuing further block granting during the 1930s adopted a more cautious approach, and during the Second World War dropped the principle of fixity for periods of years in favour of annual grants again. Similarly, the inherent inadequacy of the 1929 block grant formula to achieve more equitable distribution of grant aid was recognised at the end of the Second World War. The learning of lessons, which resulted in the post-war grant reforms, allied to the reform of rating and valuation as a necessary basis for

discerning local authority need, was one that in relation to the redistributive aim in grant aid at least could have been entirely avoided. That even the post-war reforms remained within the incremental pattern of financial reform on the basis of the grant option undermines any idea that the context of policy formulation had altered in thirty years.

Chapter six served the purpose of recording the failure of the 1929 reforms in relation to local health provision. Contrary to optimistic interpretations of health standards, and, therefore, of the adequacy of health provision in the 1930s, the Ministry of Health surveys revealed by 1935 a high level of local deficiency. The poor level of resourcing which the block grant did little to erode must have been an important factor, yet Ministry records, in wishing to deny the relevance of this factor give no clear indication as to how important. Perhaps more importantly, the Ministry surveys reveal the high number of authorities which were perceived as being generally anti-public health provision with implications for meeting local need, and how many of these authorities were in relatively more prosperous areas of the country. The Ministry surveys also show the perceived reasons for deficiency with regard to individual health services, which suggest a greater level of culpability on the part of local authorities than previous analysts have suggested. Consequently, the reform of grant aid to local authorities in 1929 had adverse effects on local provision both in terms of

inadequately helping poorer authorities to recover from positions of backwardness, and, perhaps decisively, in allowing local authorities autonomy in the usage of grant aid which encouraged local authorities in their dilatoriness. This provides grounds for believing that even if grant aid had been considerably greater to individual local authorities, even in cases of authorities in necessitous areas, local provision would not have been considerably enhanced. The problems of local health care went much deeper than that.

It is agreed then that in this context the weakness of Ministry powers in relation to grant aid was important. Section two, however, charted the way in which central-local relations were conducted in the light of this. Strenuous efforts were made through survey letters, correspondence and re-surveys to persuade deficient local authorities towards improvement. The conclusion is, however, that Ministry officials largely failed through relations with local authorities to improve on the results uncovered by 1935.

This analysis suggested the illogicality of Ministry officials continuing with the local government option as a basis for future health care reform. Yet, the final section concluded that if one understands inter-war policy making in terms of incrementalism, then such an approach was highly logical. But for the impact on the health reform debate of the Second World War and subsequent events, one could have reasonably expected the move towards a state medical service based largely upon

local government. It was also concluded, however, that the experience of the implementation of reform in the 1930s did have a dynamic effect on official thinking in relation to the grant aid finance of local health provision. The adverse effects of allowing grant aid to be non-specific, removing the percentage basis for grant funding and eroding central control so greatly on local provision were recognised. This was shown in the example of fears over local authority venereal disease services provision in the early part of the Second World War and confirmed in the reform of grant aid to local authority health provision in the new regime of the National Health Service.

However, it should be noted that even in creating a lesser role for local authorities in health provision after the Second World War and in reforming grant aid again central politicians and bureaucrats did not embrace a more wide ranging alteration of local government areas to make them better resourced and arguably more efficient. This suggests that overall the approach of central politicians and bureaucrats to the basis of the role of local government in social policy also had not changed in thirty years.

The thesis overall may, therefore, be used to explain why and how inter-war policy makers conducted local government and public policy reform in the way that they did: why reform was conducted on a limited basis and failed even in its limited aims. It also provides a context for understanding that in the post-war period the

local government structure, means of local government finance, and the role of local government in public policy, which were largely retained, may not be viewed in the light of a liberal continuum in the development of the institutions of government. An inherently incrementalist approach to reform of local government and central-local relations preserved the interests of the central governing elite whilst denying those of many outside government, despite the advent of more democratic politics.

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